PERCEPTIONS AND EXPECTATIONS OF HOSPITALISATION AND ATTITUDES TOWARDS MENTAL ILLNESS : A STUDY OF FIRST ADMISSION PSYCHIATRIC PATIENTS IN EDINBURGH, SCOTLAND AND ST JOHN'S, NEWFOUNDLAND

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For John, my parents
and Christopher

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CHAPTER 1

Introduction

This thesis examines the experience of hospitalisation of psychiatric patients admitted to hospital for the first time and their attitudes towards mental illness. The research was conducted using in-depth semi-structured interviews with a sample of 100 patients - 50 in Edinburgh admitted to the Royal Edinburgh Hospital and 50 in St John's, Newfoundland, admitted to Waterford Hospital and the Health Sciences Centre Psychiatric Unit. Much of the literature in the sociology of mental illness which addresses psychiatric hospitalisation has taken the form of a 'debate' between proponents and critics of the labelling perspective. This thesis considers the relevance of some of the issues arising from this in the understanding of these patients' experiences.

Considerable debate over the past 20 years has centred on the labelling perspective of mental illness and its criticisms of a medical model, or more specifically, a psychiatric perspective of mental illness. The labelling perspective, initially discussed in detail in Scheff's (1966) Being Mentally Ill, argues that a person can be identified as mentally ill when they break the rules governing certain societal norms. Most rule breaking goes unnoticed and tends to be transitory. Rule breaking, labelling theorists argue, only becomes 'stabilised' after it becomes recognised by others and is publicly labelled. Others respond and react to the individual in terms of a stereotype which is, Scheff (1963 and 1966) argues, initially learned in childhood and reinforced in everyday interaction. These stereotypes not only influence others' reactions to the individual but

may also shape the individual's behaviour. The individual, it is argued, is rewarded by others for conforming to the stereotype of mental illness. Thus, he or she comes to play the role of the 'mentally ill'. Labelling theory also argues that this stigmatised identity becomes the individual's dominant or 'master status' and persists over time. This perspective opposes the notion that mental illness is a clinical entity located within the individual and focusses on the social factors which result in a person being labelled mentally ill.

Defenders of the psychiatric perspective have not themselves necessarily been members of the psychiatric profession. In fact, psychiatrists themselves have not significantly entered the 'debate' - most of which has taken place between social scientists supporting one perspective or another. Nor has the dialogue been balanced. It has largely taken the form of criticisms and responses to them. The 'psychiatric perspective' has not been presented as a coherent view which reflects the fact that psychiatry itself is characterised by a wide variety of divergent perspectives. In fact, many individual psychiatrists and psychiatric policies have in many ways been influenced by labelling theory.

The sociological theory consistent with the psychiatric perspective is sick role theory. It shares many features with a medical model but looks at the individual's state in a different way. It considers that role impairment rather than pathology is indicated by symptoms. Because Scheff's (1966) attack was on a medical model of mental illness, most of the 'debate' has taken place within this context. Other sociological perspectives, such as sick role theory, have consequently

not frequently been invoked in criticisms of labelling theory. However, some researchers have pointed out that for some purposes, sick role theory may be more useful than a psychiatric perspective as a contrast to labelling theory as it avoids the complex issue of illness versus deviance. Following from this, issues arising both from the psychiatric perspective and from sick role theory will be contrasted with Scheff's version of labelling theory.

The debate subsequent to Scheff's (1966) initial formulation has centred on two areas: the definitions employed by Scheff (and much of the ambiguity in his presentation); and the empirical validity of the labelling perspective. This has focussed on the meaning of residual rule breaking, the relative importance of social factors in the process leading to the admission, attitudes held towards the mentally ill, the nature and meaning of stereotypes, and the stigma of psychiatric hospitalisation. Those critical of the labelling perspective have generally argued that the nature of the individual's condition is more influential than social factors in the process leading to hospitalisation, that hospitalisation is not automatic, that attitudes are no longer negative and that stigma is not a problem. One aspect of the debate which will not be considered here is that concerned with the nature and existence of mental illness. Labelling theory, in emphasising that mental illness arises from rule breaking being labelled, asserts that those labelled as mentally ill are not constitutionally different from those who are not labelled. They are not more disordered; it is only that some people are better placed, that is they are more powerful, to resist labelling. A strictly

clinical perspective would argue that people identified as mentally ill are more disordered than those who are not. It is not only in the sociological and psychiatric literature that there is controversy about the distinction between 'mental disorder', 'mental illness' and 'deviance', these definitions are also problematic in terms of the legislation in Britain. Within psychiatry itself there is also a debate as to what is considered amenable to psychiatric treatment. This thesis, however, is concerned only with the subjective meaning of becoming a psychiatric patient and the issues surrounding this. The defining of mental illness is beyond the scope of this work and this part of the debate will not be entered into.

Proponents of the labelling perspective and this perspective's critics have to some extent modified their stances in the series of debates which dominated the sociological literature on mental illness during the 1970s. Scheff (1974), for example, pointed to the importance of labelling as a 'sensitising theory' - as a contrast to the medial model. Gove (1982a) admitted that labelling theory had made some contributions to psychiatry, citing in particular its influence on the deinstitutionalisation movement. However, this does not mean that the two sides have compromised to the extent that a synthesis has developed (although such a synthesis has been proposed by Cockerham, 1979). In fact, despite concessions by both sides, Gove and Scheff in these same references continue to argue forcefully that the evidence supports their own positions.

Nevertheless, there seems to be some consensus among observers of the debate about the validity of both the labelling and psychiatric perspectives on the basis of empirical research findings. There seems

to be some general agreement that: (i) social factors or 'contingencies' do play a part in the route to the psychiatric hospital; (ii) hospitalisation is not automatic although presumption of illness at this stage may be; (iii) attitudes to the mentally ill, although improving, are still negative and recognition of illness is often on the basis of a stereotype; (iv) there is some stigma associated with having been a psychiatric patient but this may diminish over time and may not in fact adversely affect people's life chances.

The debate has also to be considered against developments which have taken place in the practice of psychiatry. These include changes in therapeutic practices and policies regarding admission procedures and in commitment legislation. For example, a policy of deinstitutionalisation and the emphasis on community care means, among other things, that hospitalisation is not considered the best alternative for people suffering from a psychiatric disorder and that most patients are discharged after a relatively short period of time. In addition, a much smaller proportion of patients are now admitted to hospital on a compulsory basis, particularly in the US, than when Scheff first argued his position.

Gove (1979, 1982a and 1982b) concludes that as a result of these changes the labelling perspective is 'no longer tenable'. However, Gove has been criticised for his unquestioning acceptance of and optimism about such changes (Goldstein, 1979). It seems likely that such changes are neither as extensive nor their impact so great as radically to have shifted attitudes towards psychiatric patients. Indeed, if labelling theory was only applicable to involuntarily committed patients, then its relevance in the UK and perhaps even Canada at the time Scheff wrote may be questioned.

Our understanding of the process of becoming a psychiatric patient is largely based on ideas developed from these perspectives. However, as Weinstein (1983) points out, the 'debate' has not taken as its central focus the views of patients themselves. This is surprising, as both Rotenberg (1974) and Weinstein (1983) argue, given labelling theory's roots in symbolic interactionism. But, as Becker (1974) argued, the main aim of a labelling perspective was to expand the focus in deviancy theory from the deviant and the deviant act to consider the reaction process and those reacting to the deviant.

Some recent literature, however, has addressed issues related to patients' own views and the meaning of the stereotype of mental illness in relation to self identity and has considered the labelling and psychiatric perspectives in the light of the findings. Most of this evidence is conflicting and not wholly supportive of either perspective. Apparently this is because of uncertainty about the precise implications for patients of what it means to be labelled 'mentally ill'. For example, Kennard (1974) found that patients described the mentally ill in terms of a negative stereotype but did not view themselves in terms of this stereotype. O'Mahony (1982) found that most patients did in fact accept that something was wrong with them but did not view themselves in terms of the mental illness stereotype. Townsend (1978), on the other hand, found that patients neither used stereotypes in relation to themselves nor to the mentally ill.

Whitt and Meile (1985) argue that both the labelling and sick role perspectives are problematic in that they present as 'oversocialised conception of man' (Quadango and Antonio, 1975). They and others argue that people may accept or reject labels and interpret them in different

ways. The literature, then, would seem to indicate that the issue of the adoption of the psychiatric patient role, self identity and the meaning of the mental illness stereotype is more complicated than the labelling or psychiatric/sick role perspectives would suggest.

The aim of this thesis is to explore some of the issues arising from this research and to consider the applicability of the labelling and psychiatric/sick role perspectives to the subjective experience of the process of becoming a psychiatric patient. As such it is concerned with the views of people who, although they may have previously been in a patient role, were entering the psychiatric in-patient role for the first time. This thesis examines the following issues: the self conceptions of first admission patients and their conceptions of mental illness; their perceptions of the process leading to their psychiatric admission; their expectations of hospitalisation, ward life and the patient role; and their expectations concerning stigma which may attach to hospitalisation.

If its critics are correct in that labelling theory is 'no longer tenable', we would expect to find the following: patients themselves to have voluntarily sought help; to have recognised their symptoms; not to think of mental illness, the mentally ill or themselves in a negative way or in relation to a stereotype of mental illness; to accept the patient role and not be resistant to treatment; and not to fear the consequences of having been a patient in a psychiatric hospital.

If, on the other hand, the labelling perspective is applicable there would be evidence of the following kind: that patients would perceive the process leading to their admission as one in which they had been coerced or persuaded under considerable pressure; to view the mentally ill and

themselves in a negative and stereotyped way; to be resistant (initially at least) to treatment: and to fear of the stigma of being a former psychiatric patient.

It would seem likely that a number of variables related to the psychiatric admission might affect patients' self conceptions, their views of illness and the adoption of the psychiatric patient role. Meile and Whitt (1981), for example, have suggested that labelling theory may focus on involuntary patients while sick role theory may be applicable to voluntary admission (although their data could not test this hypothesis). It would seem reasonable to suppose that this might be extended to incorporate Goffman's (1961) distinction between 'willing' and 'unwilling' patients. Other research suggests that factors such as experience, knowledge, education, age and social class affect attitudes to mental illness. Such factors may also, then, be significant in relation to the patient's own views of him or her self as mentally ill. These issues are addressed in the thesis.

Interest in these topics is not purely academic. There are some points which may have implications on a practical level. In particular, there may be a relationship between patient satisfaction and the extent to which people entering psychiatric hospitals are informed about the relationships between themselves, psychiatric staff and ward treatment ideologies and practices. This might have implications for the effectiveness of the therapeutic situation.

It may also be that there are general areas where people could be better prepared for the experience of being admitted to hospital and where public education might be indicated. In addition, the participation of other professionals in the process might indicate areas

where communication could be improved.

Finally, in investigating the meaning of psychiatric hospitalisation to patients themselves, it is of interest to question not only their anxieties, concerns and general problems but also what, if anything, they expect to obtain from the experience and if they expect to benefit from it. All of this may give some indication of the value of the psychiatric hospital from the point of view of the consumer.

CHAPTER 2

Review of the Literature

Introduction

This review will consider the literature in the area of the sociology of mental illness which contributes to our understanding of the process of becoming a psychiatric patient. The literature in this area has become increasingly extensive and diffuse over the past 35 years. Pioneering attitude studies conducted in the 1950s, the rise of the anti-psychiatry movement, and policy changes resulting in deinstitutionalisation and community care have all contributed to a heightened interest and awareness concerning both the nature of psychiatric illness and the situation of the psychiatric patient.

Much, although not all, of this literature forms part of a 'debate' between proponents and critics of the labelling perspective. Labelling theory was initially advanced as contrast to the medical model of mental illness. However, the subsequent debate has not consisted of a representative dialogue between sociologists and psychiatrists. Indeed, this discussion has been conducted almost exclusively among social scientists. Moreover, the riposte to labelling theory, although reflecting a medical or clinical perspective, has not necessarily amounted to a unified or coherent psychiatric view. If course, this partly reflects the variety of perspectives within psychiatry itself.

Part of this debate indeed concerns itself with whether psychiatric illness exists. Labelling theorists argue that mental illness arises when the breaking of residual norms becomes publicly recognised. The medical model assumes that disorder exists and is manifested in symptoms. Within psychiatry itself, however, there is also a debate as to what is 'treatable'. Thus, within the psychiatric population are

people who are considered disordered only in terms of their behaviour and who may not be thought of as 'ill' and amenable to psychiatric treatment. Although this has been central in some of the discussions between proponents of the labelling and psychiatric perspectives, the issue of whether psychiatric illness exists is not central to the concerns of this thesis and will not be considered here in detail.

Another perspective from which to view the process of becoming a psychiatric patient is that of sick role theory. It differs from the psychiatric perspective in that it considers role impairment and not psychopathology to be indicated by symptoms. Because it thus avoids the complex issue of the existence of illness it has been suggested by some researchers as an alternative contrast to the labelling perspective and one which shares some common features with a medical model. For example, as an ideal type it assumes a process of rational help-seeking behaviour and the non-problematic adoption of the patient role. However, sick role theory has not generally been utilised in the criticisms of labelling theory because Scheff's (1966) initial attack was on the medical model and the subsequent responses to this determined the pattern of the 'debate'.

In addition, largely because of labelling theory's concentration on societal reaction, the views of patients themselves have not always been taken into consideration. Yet, critics of labelling theory, in arguing that what is presented is often crudely deterministic, have pointed out that individuals may react in different ways to the experience of becoming patients. Consideration of these views would seem to be crucial to an understanding of such a process.

This review, then, will consider some of the evidence which has been advanced by proponents of these perspectives and will indicate those issues which gave rise to questions addressed in this thesis. In this it will consider four broad areas: pathways to psychiatric care and help seeking behaviour; attitudes to mental illness; patient self perceptions and attitudes; and the stigma attached to mental illness and psychiatric hospitalisation.

Pathways to the Psychiatric Hospital

The problem of why and when people 'seek' psychiatric treatment has been approached in the literature from a variety of angles and from different ideological perspectives and has been based on different interests, whether psychological, sociological or psychiatric. As a result, there is a lack of overall coherence and hence a lack of understanding of the entire process or patterns relating to why a person goes through the route to the psychiatric hospital. Here, however, an attempt will be made to overview some of this literature. This review will also consider the applicability of the labelling and psychiatric perspectives and sick role theory to this process.

The basis of Scheff's (1966) formulation, is that mental illness arises from residual rule breaking. In his initial application of a labelling perspective to mental illness, he argued that mental illness results when a person breaks the rules governing certain societal norms. As such, rule breaking is prevalent among people who are not considered mentally ill as it is usually transitory (Lemert, 1951, calls this 'primary deviation'). Scheff (1966:53) asks:

> what accounts for the small percentage of residual rule breakers who go on to deviant careers?

He answers this by saying that mental illness arises from this residual rule breaking becoming publicly recognised. When this happens, certain stereotypes of mental illness, initially learned in childhood and reinforced in everyday interaction, guide others' reactions to the individual (and may also shape the individual's behaviour when conformity to the stereotype is reinforced through approval from others). However, there are problems with what the stereotype of mental illness is and what this means for the recognition of mental illness, and this will be discussed below.

Much of the literature on illness behaviour and pathways to psychiatric care has not been considered by labelling theorists because the individual response was not central to Scheff's (1966) initial formulation. The labelling approach to mental illness, as was discussed above, concentrates on societal reaction to deviance. As discussed by Scheff, it focusses on issues which concern decisions and actions taken by other people rather than on those taken by the individual. However, a major criticism of the labelling perspective has been its deterministic nature and its failure to consider the interactive nature of the response to deviance in terms of different individual responses and interpretations and the possibility of self labelling. The literature which addresses this will also be considered here as, it will be argued, the individual response in central to the understanding of the process of becoming a psychiatric patient.

Largely because Scheff (1966) set up his initial argument to counter the medical perspective (and central to this has been the debate over residual deviance versus illness), Scheff's critics have responded in terms of this perspective. The psychiatric perspective, as a clinical

perspective, does not in itself directly address the issue of why and how people seek psychiatric care. However, it assumes that people would recognise their problems as symptomatic of an underlying illness and would seek appropriate help for these.

The sick role perspective has not generally been used as the contrast to the labelling perspective, largely as a result of the nature of the original debate. Whitt, Meile and their associates have recently, however, contrasted an ideal-type illness role theory with the labelling approach, adopting this approach, they point out, to avoid the problematic issue of deviance versus illness and the question of whether the 'mentally ill' are 'really sick' (Whitt, et al. 1979). The difference between the medical perspective and this sick role theory (derived from Parsons) is that role impairment and not pathology is indicated by symptoms (Whitt, et al. 1979:656).

In addition to the literature on illness behaviour, this review will also consider two issues which have been central to the 'debate' surrounding the labelling perspective, insofar as the process leading to the psychiatric admission is concerned. These are: (i) the relative importance of social factors or 'contingencies' as opposed to psychiatric factors in decisions regarding hospitalisation; and (ii) the presumption of illness by psychiatric decision makers and the automatic admission of people presenting at hospital.

(a) Problem recognition and help seeking behaviour

Although, as was mentioned above, the labelling perspective does not address the issue of self-labelling or help seeking behaviour on the part of individuals, much of the literature on the sociology of mental disorder focusses on these issues. Some of these findings will be reviewed here.

Meile (1986) has argued that sick role theory would lead us to expect certain behaviours; in this case that people will seek help for their problems and will not ignore them. However the literature on illness behaviour indicates that the process to the psychiatric hospital is considerably more complex than this would imply.

Kaplan (1972) has examined some of the literature on help seeking behaviour and concludes that societal norms act against the admission of problems and the seeking of help for these. Elinson et al's (1967) study on public attitudes, using a sample of New York City adults, found that although 45% of the sample could think of a time when they had had an emotional problem that might have been helped by seeing someone about it, only 8.6% said they had done so. In the same study, in response to a hypothetical situation where the respondent was asked what he would do if he had long-standing personal problems that were not improving, the most frequent response was that they would try to solve it themselves (28%); 21% said they would consult a physician; 17% a clergyman; and 13% a psychiatrist. The reasons given for people in general not seeking help were shame or embarrassment (26%); fear of the results of diagnosis or

therapy such as finding out the problem was serious (20%); ignorance about the illness (16%) and 15% gave reasons such as shyness, denial, pride and so on. Overall, Kaplan's (1972) conclusions that people avoid psychiatric aid seem warranted.

However, there seems to be some ambiguity on information relating to the help seeking process and the conclusions that can be drawn from some of this. From Elinson et al's (1967) results, Kaplan (1972) states that ignorance did not seem of major importance, given the evidence relating to experience. 52% knew personally someone who had help for emotional problems, 27% had relatives in that position, and 18% knew someone who had been hospitalised for such problems. On the other hand, Kaplan (1972:91) in discussing the same study, on the problem of why people do not anticipate seeking psychiatric help, states that one of the reasons is lack of personal experience with psychiatrists or therapy - that is the non-existence for the majority of people of a psychiatrist in their social circle. Other reasons for this non-anticipation are stated as a 'confusion about the psychiatric role', an 'uneven knowledge of the psychiatric help seeking process' and probably, more importantly, the idea of the family physician as being the most important help source.

Other factors may be influential in help seeking. Robbins (1981) was interested in the relationship between perceived causes of emotional problems, psychiatric sophistication and help seeking. A mail questionnaire included hypothetical case descriptions and respondents were asked: if they knew someone

who behaved similarly to that described in the vignettes; if they thought 'anything was wrong' with the person described; if they thought they had 'some kind of mental illness' and if they thought they should consult a doctor.

Respondents were also asked if, for a personal, emotional or psychological problem, they would consult a psychiatrist, psychologist or psychiatric social worker. The questionnaire also included details of exposure to psychiatric or psychological terminology and courses taken in psychology.

Robbins (1981) found that subjects attributing causes of emotional problems to disposition rather than the environment were more likely to seek psychological or psychiatric help. This former view was more likely to be adhered to by those with greater psychiatric sophistication and contact.

The role of significant others is central to much of the literature on help seeking behaviour. Freidson (1961) points to the importance of lay consultation within the household prior to consulting a doctor. This lay consultation was found to be external to the household if the symptoms or problems were not self evident. Freidson (1961) also found that if these problems presented diffuse complaints such as interpersonal problems, then normalisation by the lay members consulted was possible and consultation with a physician discouraged.

Similarly Kadushin (1969) found that significant others were central in both problem recognition and the decision to consult the medical profession. In interviews with people arriving at various psychiatric clinics in New York, he found that between

80% and 90% had first consulted other people. Kadushin (1969) argues that recognition of problems depends not only on the perception of pain but also on problem identification by others, although in the majority of cases this is only to confirm what the individual already knows.

Yokopenic et al (1983) point to the evidence suggesting that a great deal of psychiatric disorder in the community remains untreated. In their study over 1,000 adults in California were asked about their consultations in the previous year for emotional or family problems with a physician, a psychiatrist, a psychologist, a social worker, a counsellor, a mental health clinic, a marriage or child guidance clinic, a psychiatric hospital or a religious leader. They were also asked if they had had any emotional or family problems during the previous year for which they could have used help. These problems were identified from a check list.

Psychiatric sophistication was measured with educational level, knowledge of others having consulted a mental health professional and past personal experience of this. The respondents were also asked if they had discussed problems with friends or relatives. Present level of depressive symptoms were measured with the 'CES-D' scale - focussing on the frequency of a variety of depressive symptoms experienced during the previous week.

Yokopenic et al (1983) found that, when symptoms levels were controlled, prior use of a mental health service by the individual or by friends or relatives enhanced the recognition of

problems. Women were more likely than men to report depressive problems and to label them depression (although they were no more likely to recognise problems other than depression). Education also enhanced depression recognition. Lay consultation was also found to be important with 78% of the respondents reporting that they had done this.

Overall the three influential factors in the decision to use services were symptoms, type of advice from friends or relatives and previous exposure to such services. Of those who had not sought help, 11% mentioned a negative attitude including the fear of stigma, 12% gave lack of time, money or transportation as a reason but a large number - 73% - said they felt they could deal with the problem by themselves or with help from a friend.

It has frequently been noted that females more than males report symptoms, seek help and are hospitalised. A societal reaction perspective, in arguing that people in powerful positions are more able to resist labelling and hospitalisation, would account for male/female differences in terms of relative power. Theoretically, a medical perspective would stress differences in prevalence.

Phillips and Segal (1969) conducted interviews, one year apart, with 278 adults in a small New England town. On the assumption that it is culturally less appropriate for men to be ill, upset or emotionally disturbed than for women, and that men are expected to be more self-controlled when they are ill or face difficulties and conversely that it is more appropriate for women to express their problems, Phillips and Segal (1969) argued that

women would be more likely to report such behaviours and acts that would lead to their being defined as mentally ill. They hypothesised that women would report a greater number of psychiatric symptoms than men (with the same number of physical illnesses). Using Langer's 22-item Mental Health Index, their data supported their hypothesis, stressing that this may not be due so much to sex differences in the prevalence as the reluctance of men to report such problems. Other research along similar lines has also indicated that differences in attitudes and recognition levels, varying among social classes, ethnic groups, age and education levels, can also influence the reporting of symptoms.

Clancy and Gove (1974) argue against Phillips and Segal's (1969) interpretations and consider that differences in reported rates reflect differences in symptoms.

In an attempt to investigate this problem, Horwitz (1977) interviewed 80 women and 40 men - all patients at a community mental health centre. From his findings, he argues that as women are considerably more likely than men to discuss their problems with friends, their problems are more likely to become visible at an early stage. A help source may be suggested and women are more likely to want treatment or willingly accept it. Men, argues Horwitz (1977), are more likely to hide their problems and not receive help early. Treatment is likely only when their behaviour becomes so visible and disruptive that others initiate some action leading to this. He also found that women had successfully labelled their

husbands only when the men were in relatively weak positions of power.

The issue of sex differences in help seeking and hospitalisation, as all issues in this area, is complex and no one theory appears adequate as an explanation.

A moral dimension seems to play an important role in the avoidance of help seeking. This is not surprising if indeed mental illness and the mentally ill are considered in a negative stereotyped way (and this will be discussed below). This is somewhat evident in much of the research findings, including Elinson et al (1967) and in Yokopenic et al (1983) - both reported here. Perhaps the difference in the percentage citing embarrassment or a fear of stigma (26% in 1967 and 11% in 1983) indicate a move in the direction of viewing mental illness less negatively. Meile (1986) has pointed to Freidson's (1970) criticism of Parson's failure to include stigmatisation and implications of moral deficiency in his model.

Similarly self-reliance would seem to deter help seeking. This is also supported in Elinson et al (1967) - with 28% saying they would solve problems themselves and in Yokopenic et al (1983) - with 73% saying they would deal with a problem by themselves or with help from a friend. Meile (1986) also found a large number of subjects who said, when asked to consider 36 problems and the type of appropriate help source, that they would deal with these by themselves or do nothing about them. This was most marked in those over 45 and those low on the Langer Index. As Meile (1986) points out, such findings are

not supportive of sick role theory.

However, it is not necessary for people to seek help for problems they recognise as psychiatric. This is largely because of the central role of the physician in the referral process. The literature on help seeking behaviour indicates that the GP or family doctor plays a crucial role at this stage. Gordon et al (1979), for example, in a study in Aberdeen, found that for half of the patients studied, the GP was the first professional contact. Desroches (1983) in a study of 40 first admission patients in Ontario found a similar referral pattern. Sixteen patients had been sent directly and 18 had been referred by their GPs to a psychiatric hospital. Another four had been referred by their GPs to medical specialists who had then made the psychiatric referral.

Even in the US where consultation and referral to psychiatry is more diverse because of the variety of specialist clinics, private practice, direct specialist consultation, private and State hospitals, the family physician probably plays an important role. Liberman (1967), for example, found that 70% of the first admission patients in his study had consulted their physicians for help. Kaplan (1972) in summarising such literature argues that probably the most important reason that people do not anticipate seeking psychiatric help is the idea of the family physician as their most important help source.

In addition, the literature has generally found that family doctors are not only important in terms of appropriateness but also because of their accessibility - a factor which is crucial

for those consulting on the NHS in Britain and in Canada through Government-run health insurance schemes. So as well as attitudes regarding psychiatry, the actual structure of health services on any given community may influence help seeking behaviour.

The pathway to the psychiatric hospital would certainly appear to be more complex than labelling theorists seemed to suggest and the attitudes and actions of a wide variety of people and agencies need to be taken into consideration.

Some of the similarities and differences in Britain and the United States in pathways to the psychiatric hospital have been considered by Goldberg and Huxley (1980). They argue that in both countries the detection and management of psychiatric disorders is largely performed by the family physician. They look at five different stages and four filters through which the patient generally passes leading to hospitalisation. The first is the community, and passing through this filter is determined by illness behaviour of the patient. Symptoms may be ignored and treatment delayed, but they may be expressed to significant others before deciding to consult a doctor. The next stage is the consultation and thus the legitimation of the sick role. Social variables, sexual status and the amount of distress are all likely to play a part in determining help at this stage.

It is of course possible in the United States and Canada for the first filter to lead directly to psychiatric care, but Goldberg and Huxley (1980:53) argue that most will go through

the whole process. They say that if people are going to refer themselves directly to psychiatric services, they need to know about them and the evidence suggests that this knowledge is lacking.

At level 2 there are various factors which will determine whether a person's psychiatric disorder is detected. Patients, Goldberg and Huxley (1980) argue, usually report their problems in non-specific terms such as somatic symptoms or they state such problems as 'being under the weather'. The ability to pass through the second filter to the third stage where the patient is identified as psychiatrically sick by their physician is determined by a number of variables relating both to the physician himself, his beliefs and attitudes, and to the patient.

Goldberg and Huxley (1980) continue that in both the United States and the United Kingdom the physician acts as the referral through the third filter to out-patient psychiatry, although they do admit that in the United States the second and third filters can be short-circuited. The fourth stage involves private office and out-patient consultation with psychiatrists, and the fourth filter can lead to in-patient treatment. They stress here that by level 4, where the patient is first seen by the psychiatrist, he usually has been given a descriptive diagnosis label and it cannot really be said that the psychiatrist is defining psychiatric illnesses (Goldberg and Huxley, 1980:131). However, more needs to be known about the individuals involved in the definitional process

and the interaction between them and the 'future patients'.

Whitt and Meile (1985) have discussed the process of problem recognition in the pathway to psychiatric help. The individual, they argue, comes to recognise that something is wrong when an accumulation of problems or symptoms reaches a critical point. This they call 'snowballing'. This is followed by 'magnification' where although the individual feels something is wrong, those around him or her consider he or she is exaggerating. They cite Yarrow et al's (1955) findings, where the husbands recognised their own problems before their wives did, as evidence of this process. At this stage, Whitt and Meile (1985) say, people may engage in 'aligning actions' - such as thinking the problem will go away in time. The individual will then turn, as the literature on help seeking finds, to family, friends, physicians and the clergy. Eventually they will consult the psychiatric profession. Whitt and Meile (1985) make it clear that even at this stage people do not necessarily see themselves as mentally ill - only that there is nothing left to do about their problematic feelings.

Thoits (1985) takes up some of the issues concerning the applicability of labelling theory - that is its restriction to involuntary patients. She attempts to develop a perspective from which to view voluntary patients - a theory of 'self-labelling'. She argues that people can self-label because they can compare their own feelings and behaviour from the perspective of the wider community. It is not necessary for them to verbalise this as mental illness, they may simply

consider something is wrong with them. However, they will have partly identified such feelings and behaviours with cultural imagery about mental illness.

The major problem in drawing conclusions from this type of research in trying to clarify the picture on help seeking behaviour is that it is based largely on hypothetical questions. There is some evidence, as Tuckett (1976a) points out, which indicates that people do not actually behave as they say they would. For example, although Dunnell and Cartwright (1972) found that 72% of respondents said they would see a doctor for a constant feeling of depression, Brown et al (1975) found that only half of those who had had serious depressive symptoms for some time were receiving help for these.

Such findings have implications for the understanding both of pathways to the psychiatric hospital and of the detection of psychiatric disorder in the community. Goldberg and Huxley (1980), for example, say that surveys indicate that there is considerable variation in the rates of reported psychiatric illness by physicians. They argue that differences in detection rates are based on the physicians' concepts of psychiatric disorder and the threshold they use to identify this and conclude by saying:

> ... a doctor who tells you that 80 percent of his patients are psychiatrically disordered is no more likely to have a greater number of such patients attending his office than a doctor who tells you that only 10 percent are disordered.
> (Goldberg and Huxley, 1980:62)

As was mentioned above, the literature which supports the labelling perspective concentrates not on the individual response but on the societal reaction process.

Goffman (1961) argued that in the US only a small number of persons entered psychiatric hospitals willingly. He therefore concentrates his argument on the majority unwilling patients. In the process leading to the hospital, he argues, other people play different parts. There is the next-of relation, the complainant and mediators (agents or agencies to whom the patient is referred and who process him in the route to the hospital). Goffman (1961) says that other people may act as 'complainants' and take action resulting in hospitalisation, but such actions do not always lead to this. Whether or not a person is hospitalised may depend on the existence of a number of contingencies - which, among others, Goffman takes to include

> socio-economic status, visibility of the offence, proximity to a mental hospital, amount of treatment facilities available, and community regard for the type of treatment given in available hospitals. (Goffman, 1961:126)

This issue of 'contingencies' subsequently became part of the argument between labelling theory and its critics.

Despite labelling perspective's emphasis on the reaction of others to the deviant and the exclusionary actions taken, the literature which addresses directly the role of significant others does not always support such a perspective. The issue of when and why others identify a person as 'mentally ill' relates to the complex area of public attitudes and the

stereotype of mental illness - this will be discussed below.

Evidence that families do not necessarily recognise illness is provided by Yarrow et al (1955). This study is frequently cited in the literature as evidence for denial or delay within the family when faced with the mental illness of one of its members. Yarrow et al (1955) used wives' reconstructions of their earlier experiences and their reactions during the husband's hospitalisation. Yarrow et al (1955) were interested in the factors leading to the recognition of the husband as being mentally ill or in need of hospitalisation, and the process by which the wife tries to interpret the signs of her husband's illness. They found that early interpretation can be based on physical or character problems, or the environment. However, when and why behaviour is perceived as problematic seems to be an individual matter. It can be when the wife can no longer manage the husband, or when his behaviour destroys the status quo, or when she cannot explain his behaviour.

One interesting point made by Yarrow et al (1955) is that the wife's threshold for perceiving the problem does not seem to be affected by whether the husband's behaviour is public or private. Another interesting finding is that in the initial stages (although these views are not held by the wives with great confidence) the wives more often perceived psychoneurotics than psychotics as having emotional problems or being mentally ill, despite the fact that the wives of the psychotics reported more clinical signs such as bizarre, delusional or aggressive behaviour.

Yarrow et al (1955) found three patterns of redefinition by

the wives. Firstly, less than half the cases were characterised by 'progressive intensification', that is the behaviour is interpreted progressively towards a definition of its being mental illness. Second, seen in about one-fifth of the cases, the wives looked around for situationally adequate explanations. Perception of mental illness seemed to be precipitated by situational factors, such as an immediate physical threat or the influence of others. Third, involving one-third of the wives, denial continued throughout.

Despite the fact that this paper was published as far back as 1955, it has continually been cited as evidence that hospitalisation only occurs when behaviour is thought to be serious (cf. Gove, 1970; Clausen and Huffine, 1975; Horwitz, 1977; Townsend, 1978; Meile and Whitt, 1981; Desroches, 1983). This is to some extent because few studies have systemically examined the problem in such a way and also because it provides evidence for the critics of the labelling perspective.

In a study with similar aims, Sampson et al (1962) looked at types of accommodations which develop within families and how these accommodations collapse, resulting in hospitalisation. These accommodations are patterns which develop and permit (or force) a disturbed individual to remain in the community. Sampson et al studied 17 families where the wife had been hospitalised and diagnosed as schizophrenic. Interviews with the participants, as well as with other relatives, psychiatrists and other professional staff and agencies were employed. They also used medical and social records and direct observation.

Two distinct types of 'accommodation' were found.

In the first situation, the family lived together as relatively independent and self-contained. At some point, usually early in the marriage, one or both of the partners had felt dissatisfaction with the marriage. The marriages were then characterised by mutual withdrawal by husband and wife. The accommodation was characterised by emotional distance, isolation and lack of demand on the other partner, with the wives becoming acutely disturbed, but because of the accommodative pattern, family life was not disrupted. This pattern was eventually broken when withdrawal eventually became intolerable to one or other partner and pressure was brought to bear for change. Usually the disruption was started by one and resisted by the other. Eventually, this led to extreme deviance by the wife which resulted in community attention and hospitalisation.

The second type of accommodation was found in rather different family situations where life was organised around a third figure, usually a mother or mother-in-law, who carried out the wife's maternal and domestic functions. Here the wife did not withdraw, but sickness resulted in maternal interference and concern. The husband then characteristically aided the mother, this was then seen as threatening by the wife, and resulted in rebellion on her part. Then her husband co-operated with his wife to exclude the mother. When this last stage was not established, then the wife came in contact with medical help.

Sampson et al (1962) argue that they were attempting to go beyond the information which simply states that families 'tolerate'

deviant behaviour, or 'resist' recognition, by systematically analysing types of 'typical' accommodation which delay but eventually can result in hospitalisation. While this type of study is interesting, it does seem limited, especially as Sampson et al (1962) were discussing only one type of patient, females diagnosed as schizophrenic. In addition such reports remain rather anecdotal and do not immediately or readily aid in a more comprehensive understanding of the problem.

Another study, done in retrospect, attempted to focus on the patient and his family and perhaps does help illuminate just why and when a person becomes hospitalsed. Wood et al (1960) examined the role of others in the path to hospitalisation in a V A Hospital in Connecticut. During the period of study 60 patients were admitted to the psychiatric ward, and 48 of these were used. In 23 of the 48 cases family members were also seen. The majority of the patients had been ill for a while prior to hospitalisation - 31 had been ill for longer than one year. In addition, 27 had had previous hospitalisations. The question posed was just why these people apply for admission at that particular time.

Two patient groups emerged from the data, a 'Family Group' and a 'Patient Group'. There were 13 cases in the former group, where action by someone else, usually family, preceded admission and 35 in the latter group, where the patient initiated the process.

Wood et al (1960) compared the patients' attitudes to hospitalisation with those of their families, and found that 57%

of the patients thought that it was good for their families, with 8% considering it was bad for the family and 35% thought that it would not affect the family. The families, however, were more or less equally divided among these three views.

The patients did not tend to see other people or their environment at fault, but rather focussed on the relief of their own symptoms. However the researchers found that prior to hospitalisation there was considerable evidence of conflict or changes in the lives of the patients - 65% reported conflict with people close to them; 77% indicated conflicts or changes; 63% reported changes in their lives, over half of these being factors such as separations, the birth of a child, and so on. Wood et al (1960) say that although it cannot be said conclusively that these conflicts and changes brought about hospitalisation, it does seem that they played an important part in this process.

From this evidence and the evidence relating to the conflict in ideas over the patient's hospitalisation, the writers argue that hospitalisation seems to follow demands for a change in the patients' behaviour by others (in the 'Family Group') while the 'Patient Group' seemed to use hospitalisation in an attempt to influence family members to change their behaviour.

(b) Social factors and decisions about hospitalisation

A major thrust of the 'debate' between the labelling and psychiatric perspectives has concerned the relative importance of social factors or 'contingencies' (extra-psychiatric or non-clinical factors) in the process leading to the admission and

decisions regarding the admission itself (and also in relation to length of hospitalisation and discharge from hospital). The labelling perspective has argued that social factors are more important than the individual's level of disturbance, while critics of this approach and defenders of the psychiatric perspective have argued that decisions are based on clinical considerations.

Scheff (1974) argued from his review of the literature that when patients' conditions are controlled for, then social factors were indeed influential both in the commitment process and in length of hospitalisation. He also points out, in response to his critics, that although the labelling perspective is concerned with contingencies, this does not exclude the patient's condition. Apparently the discussion concerned the relative importance of these factors.

On the opposing side, Gove and Howell (1974) looked at social class and social supports and found that high resource people were more likely to reach the psychiatric hospital as a last step, whereas for low resource people this was most likely to be their first step. They also found that people close to high income individuals were more likely to initiate hospitalisation but for low income people this was most often 'distant agents' (Gove and Howell, 1974:193). Their conclusions, which they argue, support a psychiatric perspective, indicate that lower class individuals are more likely to delay seeking help, to have negative attitudes and to reach hospital after persons distant from them have taken some action. This, they say, contradicts

the labelling perspective which argues that people with greatest resources would be most likely to resist hospitalisation.

The meaning of Gove and Howell's (1974) findings have, however, been queried. Cockerham (1979), for example, has argued that if it is high resource persons who are most likely to be hospitalised, as Gove and Howell suggest, then their findings question the direction of labelling theory rather than the perspective's validity. Gove and Howell (1974) have also been criticised because of the specialised nature of the psychiatric programme studied. It was experimental, had intensive family involvement and encouraged early discharge.

This part of the debate is confused by numerous criticisms - both methodological and theoretical. These criticisms come from both sides of the argument as well as from neutral observers. Questions have arisen over the lack of control groups (Krohn and Akers, 1977), a failure to differentiate between voluntary and involuntary confinements and what this means for the different perspectives (Chauncey, 1975).

Observers of the debate have drawn different conclusions from the evidence. Krohn and Akers (1977) conclude that most studies contradicted the psychiatric perspective. However they also point out that findings of social factors as influential is not unique to the labelling perspective. Cockerham (1979) also finds that most studies support Scheff's position - that the most marginal are least likely to be able to resist hospitalisation. Goldstein (1979), however, considers he found less consistency than did Krohn and Akers.

The confusion surrounding this aspect of the debate is not assisted by a lack of clarity concerning what the psychiatric perspective's position is. Gove (1979), arguing on its behalf, has pointed to the distinction between the psychiatric concept of mental illness and the field of psychiatry. The former, he points out, is not related to social contingencies while the latter is. In support of this he cites his own findings (Gove and Howell, 1974) that contingencies were related to psychiatric admissions. Gove (1982) argues that psychiatrists themselves would not be surprised to find out that social factors are influential in decisions regarding who is admitted to hospital. He further argues that the labelling perspective has maintained its dominant position simply because findings indicating the influence of social factors are taken without question to support the labelling perspective. Gove (1979 and 1982) basically argues that these results do not detract from the validity of the psychiatric perspective.

Another aspect of the 'debate' has focussed on the issue of illness presumption and the automatic admission of patients. Rosenhan's (1973) pseudopatients, for example, were reported to have been automatically admitted to hospital and their symptoms to be manifestations of illness.

Mechanic (1968) also reports that in two hospitals studied he did not observe one case where the psychiatrist told the patient he did not need treatment and that all patients, no matter what their functional ability, were admitted to the patient population. According to Mechanic (1968) it is the

family, fellow employees, friends and employers who play an important role in bringing the individual to psychiatric treatment, or external authorities if the behaviour is visible and disturbing. The individual himself, alternatively, may recognise that his feelings or behaviour are different from the past and define himself as ill and in need of treatment. Whatever, because of a lack of time and in using an abstract theoretical approach, Mechanic (1968) argues that the physician who first contacts the patient defined as ill by others will likely make the assumption of illness.

Scheff (1967) too makes similar statements when considering the legal aspects of the societal reaction to deviance. In a paper on the commitment and hospitalisation, he examines the differences in processes in rural and urban courts. Taking metropolitan and non-metropolitan jurisdictions, Scheff (1967) utilised interviews with judges, psychiatrists, officials and observations of judicial hearings, psychiatric interviews in four jurisdictions. He found that in three of the four metropolitan courts, the civil procedures were largely ceremonial and had little investigatory purpose. However, in nine of the 16 other counties, there seemed to be more investigatory purpose. He concludes that the presumption of illness is more associated with metropolitan areas (Scheff, 1967:110). Several reasons are cited for this: (i) in metropolitan areas there is a lack of time; (ii) there is political pressure, that is public sentiment against releasing a person who perhaps should have been detained. While found in both types of area, there is less sensational

treatment in the newspapers of such mistakes in rural areas; (iii) there is more familiarity on the part of the court officials in rural areas and personal knowledge of either the patient or his family; (iv) in rural areas, the judges are less likely to use a psychiatric framework and to rely on commonsense. In addition Scheff also argues that such factors as a person's knowledge of his rights, if he is articulate, if he retains a lawyer, will be important in his obtaining a summary release from hospital.

The idea of presumption of illness is reported in greater detail by Scheff in another paper. Here he argues that it is in the face of uncertainty that this presumption is made by the court and by the court psychiatrists. Scheff (1968) requested that all admitting psychiatrists in three large hospitals in a State complete a questionnaire for their first ten consecutive patients; 223 were returned and 59 were excluded as voluntary patients. Of the 164 involuntary patients, 10 met both qualifications for involuntary confinement - that is 'harmful to self or others' and 'mental impairment'. 21 were considered severely mentally impaired but not dangerous; 29 dangerous but not mentally impaired. 102 were noted as neither.

Scheff (1968) stresses that in these circumstances the denial which is found in societal reaction in the community is reversed and the amount and degree of deviance is exaggerated. He stresses that the severity of societal reaction may thus in part be influenced by whether or not official notice is brought to bear upon a particular case.

Mishler and Waxler (1968), however, found evidence which indicates that admission is not automatic. They compared patients who were referred, accepted and admitted, with those who were rejected at these different stages. They compared two hospitals - a State supported Massachussetts Mental Health Centre and a private psychiatric hospital. They recorded all inquiries related to hospitalisation during an eleven week period.

At the State hospital there were 246 requests for admission, 93 of whom were accepted and 64 admitted. At the private hospital of 136 requests, 79 were admitted. At the State hospital four variables differentiated between those selected and non-selected: (a) if the referring agency was a physician; (b) at inquiry, if the patient's relative was mentioned; (c) patient's age; and (d) previous hospitalisation. However, once the patient was accepted at the hospital, these variables did not discriminate among those admitted and not admitted. Because there was no point which would be distinguished between acceptance and admission at the private hospital, only those admitted versus non-admitted could be compared. Variables (a) and (b) were found to distinguish between these.

Mishler and Waxler (1968) also found that if a person was referred by a physician and not accepted, he was more likely to stay out of other hospitals but if he was referred by relatives admission to another psychiatric facility was more likely. The former process would seem, they argue, to be based on a selective decision by the physician, whereas the latter is a generalised to hospitalisation. The authors do admit that they cannot be sure

how these variables are taken into consideration by the authorities in the decision process and more information is required. Other variables too may also play an important part, such as diagnosis, social class, incapacity and the family's tolerance for deviance.

This study was cited by Gove (1970) as evidence for one of his initial attacks on the labelling perspective.

Although previous hospitalisation in Mishler and Waxler's (1968) study did not appear to affect decisions about admissions, such a history may have some influence in the decision making process (this factor differentiating between patients selected and not selected in the same study).

McGregor (1983) in a study of 94 compulsory admissions to the Royal Edinburgh Hospital found that there was no clear evidence that more effort went into avoiding a compulsory order for first admission patients than for other admissions, but that Mental Health Officers were more concerned about such orders in such instances. She also found that a number of patients (10) said they felt relief about being in hospital which she argues means that willingness to be in hospital was not enough to avoid a compulsory order.

Of course since Scheff (1966) wrote his initial argument conditions have changed considerably in the US, partly in response to some of the issues raised by proponents of the labelling perspective. Scheff (1975) points out that a replication of his study, which found the automatic admission of patients to hospital, resulted in the Lanterman-Petris-Short Law (1969) in

California and the change of regulations regarding commitment. Such changes, of course, may further question the validity of the labelling perspective. As Gove and Howell (1974) point out, this perspective tends not to make the important distinction between voluntary and committed patients and in general does not explain voluntary admissions other than stressing that they would have been pressured into an admission. With the deinstitutionalisation movement both duration of stay and numbers admitted on an involuntary basis have been considerably reduced (Gove, 1982a; Morrisey, 1982). These and other changes in psychiatric practice have led Gove (1982b:308) to conclude that "A general labelling explanation of mental illness is no longer tenable". Goldstein (1979), however, considers that Gove has been overly optimistic and uncritical in his acceptance of changes in psychiatry.

The applicability of the labelling perspective, even at the height of its popularity, in relation to the issues of illness assumption and automatic admission to hospital, was possibly questionable in the British context where conditions for compulsory admission differed considerably from the situation in the US. Scheff (1975), however, in response to such criticisms, has argued from his observations of a hospital in London that the rates of acceptance and the thoroughness of the psychiatric examinations were identical to those he observed in the US.

Attitudes towards mental illness and the mentally ill

In the plethora of literature in the field of attitudes towards mental illness, numerous aspects can be focussed upon. For the purposes of this exercise, some of the research in the following areas will be outlined: the definition and nature of mental illness as seen by the public; attitudes and information regarding mental illness (although this area is frequently combined with material on information regarding psychiatrists, other help sources, psychiatric hospitals and help seeking behaviour), and the problem of attitude change. In addition, attitudes towards mental illness and the mentally ill on the part of patients themselves, the psychiatric professionals, teachers, general practitioners, and more or less any group conceivably relevant, have been researched. Here we will concentrate on public attitudes, although occasionally it is necessary to include some material from the psychiatric professions, as their attitudes and opinions are frequently used for comparative purposes.

Most of the literature in this area has been published in the past 35 years, and the area has consistently remained one of considerable interest, frequently giving rise to more problems, both theoretical and practical, than it actually solved. In 1950, Redlich stated that there was a basic problem in that little was known regarding the ideas and feelings of the 'normal population' to psychiatry (Redlich, 1950:64). In a study which he conducted in the late 1940s, he found that 'schizophrenia' as a term was virtually unknown, 'psychiatrist' and 'psychologist' were not differentiated clearly and terms such as 'nervous' and 'hysterical'

had multiple meanings associated with them.

In an attempt to impart information regarding psychiatry to the public, Redlich (1950) gave sentence-completion tests and open-ended questionnaires to 750 adults. These questions were based on four topics: (a) the professional background of the psychiatrist; (b) indications for treatment; (c) causes of behavioural disorders; and (d) the nature of psychotherapy. Here we focus on (b) and (c). In answer to the question 'Who should consult a psychiatrist for his troubles?' 75% thought 'nervous-neurotic people', 'the insane' and 'people with sexual perversions', and 50% thought alcoholics, prison inmates, mental deficients and 'children with night terrors' should consult (Redlich, 1950:68). On the subject of the causes of mental disorders, Redlich found that 59% cited heredity factors in 'few cases', 29% in 'most cases'. 39% considered that organic brain damage caused either 'no psychiatric problems' or 'most psychiatric problems'. Redlich argues that while it is unnecessary for the public to have totally encompassing knowledge of psychiatry, some clarification is required and matters such as negative attitudes towards psychiatrists reduced. His findings on opinions relating to heredity in the aetiology of mental illness, he considers, reflects outdated scientific assumptions (Redlich, 1950:74).

Optimistically, from a study done in 1950 of 3,971 adults in Louisville, Woodward (1956) concludes that:

> Folk beliefs concerning causes of mental disorder, folk attitudes toward the victims of such disorder and folk prescriptions for treatment are all giving way to concepts and attitudes based on modern science. (1956:482)

The ideas that mental illness as a sickness, evoking sympathy and understanding and requiring some type of professional treatment, continues Woodward, are replacing the old ideas that the mentally ill were either bad and dangerous or ludicrous and silly. He found, however, that these attitudes varied with two factors - age and education; the younger and more educated being more 'scientific humanitarian'. The majority of the total sample doubted that 'most mental illness is inherited' and about half said they would not hesitate to tell friends and acquaintances that a family member had a mental illness. When Woodward gave two case descriptions (short statements on a person's feeling and behaviour) he found little support for 'protective-punitive' actions, such as locking the person in a mental hospital, when they were asked what should be done. This, he suggests, is a feeling of 'strong disinclination to bringing disgrace on anyone unless absolutely necessary' (1956:489).

Star's (1955 and 1956) instruments and report results have been used in much of the subsequent research in this area. In intensive interviews with 3,500 adults when people were asked what was meant by mental illness, it was found that they had difficulty in verbalising what was meant by this term, although they did have ideas on the characteristics of the mentally ill. They found that at least half of the respondents equated mental illness with

psychosis, but that there was confusion over other mental illnesses. They did not see a 'nervous breakdown' as a mental illness, because, as Star points out, they consider such a person is 'not out of his mind and can recover from it' (1955:2). This indication that mental illness had different meanings for the public, also seen in Redlich's (1950) discovery of the public understanding of the terms 'nervous' and 'hysterical' has subsequently been considered as an important variable in this area of research.

Part of a large survey reported by Elinson et al (1967) examined the public's perceptions and conceptions of mental illness in a study of 2,000 New York City adults. As an explanation for mental illness, socio-environmental factors were stressed more than organic, hereditary or moralistic factors. For example, as causes, the following agreed with: 'the mental illness of many people is caused by a lot of fighting and quarrelling between their parents during childhood' (61%); 'the mental illness of many people is caused by the separation or divorce of their parents during childhood' (57%); while only 44% agree that 'a mental illness can happen just because it runs in the family'. Under half agreed with the organic aetiology and about half agreed that a main causal factor in mental illness is lack of moral strength or willpower (1967:17).

On the nature and course of mental illness, a majority agreed with the statement that 'mental illness is an illness like any other' (69%), but 77% agreed with the statement that 'unlike physical illness, which makes most people sympathetic, mental

illness tends to repel people'. However, Elinson et al (1967:18) also found that only 10% admitted to being personally repelled by mental illness while most people considered that others would be repelled. On the public image of the mentally ill, 80% rejected 'to become a patient in a mental hospital is to become a failure for life', but 76% thought that patients were 'in many ways like children'. Elinson et al (1967) argue from this that there is some evidence that some attitudes and opinions about mental illness are held with a relatively high degree of consensus by the public. There was a variation in consensus on the types of behaviour defined as illness. For example, they found that 91% agreed that a 'clear sign of illness' was indicated by a man who wears his wife's clothes. Other evidence for such consensus was found when over two-thirds of the sample agreed that the following was a 'clear sign of illness': 'A man who threatens to kill his wife, saying she is against him like everyone else is'; 'A mother who has thoughts that she might destroy her baby'. However, on other types of behaviour opinion was clearly divided. There was a lack of consensus on 'A young woman always in an unhappy mood, feels that nobody cares for her and that she isn't much good' and 'A cheerful girl is afraid to use an elevator and always has to go back to see that the door is locked and the gas stove turned off' (Elinson et al. 1967:23).

Elinson et al (1967) also used a social distance scale regarding attitudes to former mental patients, a method replicated in much of the research frequently with similar results. Their public agreed in the following ways: work next to on a

job 73%; live next door to 69%; hire 64%; as a boss on a job 46%; share an apartment with 23%; marry someone in the family 23%.

Cumming and Cumming conducted a study in 1951 in two communities in a prairie province in Canada. It was in essence a controlled experiment designed to change the community's attitudes towards mental illness with an intensive educational programme, and used an experimental community and a similar control community. A questionnaire was developed from Star's interview schedule with two attitude scales and was given to all the adults in the experimental community (1,500) and to 102 adults in the control community (Cumming and Cumming, 1957:9). These were administered immediately prior to the six months intensive educational programme and again immediately after the programme. The term 'mental illness' was used, but what was meant by it was not specified by the researchers, in order to obtain a full range of meaning. In addition, 100 interviews before the programme and 70 after were conducted with a random sample of adults in the experimental community, based on their conceptualisation of 'mental illness' as they had responded in the questionnaire, in order to investigate these meanings in detail. The education programme itself consisted of such things as radio programmes, newspaper articles, a film festival, meetings and lectures, and discussion groups.

Of the questionnaires returned, 540 (60% of the sample) had answered more than half the questions and these results were used in the analysis. The items yielded two scales, 'social distance'

and 'social responsibility'. Social distance measured 'how close a relationship the respondent is prepared to tolerate with someone who has been mentally ill' and social responsibility measured (a) 'responsibility for causing illness and (b) responsibility for assuming the social burden which the mentally ill person places on society' (Cumming and Cumming, 1957:54). The social distance scale, like the one subsequently used by Elinson et al. included statements on marrying an ex-patient, falling in love with, sharing a room with, selling an empty lot nextdoor to, sponsoring an ex-patient as a member in a favourite club or society. Social responsibility included statements such as 'people in communities from which the mentally ill come should be considered partially responsible for their breakdown'. Insofar as social distance was concerned, younger, better-educated people indicated they felt able to tolerate more contact with mental illness than the older, less-educated. 'Social responsibility' was unaffected by these variables. However, when they compared the before and after sources, and compared those with the control group, little difference was observed (Cumming and Cumming, 1957:87). In other words, the programme had little impact on these attitudes.

On the causes of mental illness, the results from the questionnaire were as follows: 172 mentioned biological reasons, 207 mentioned the personality of the ill person, 133 mentioned disruption of the social system, 99 mentioned reasons related to culture and 80 mentioned economic causes. From the responses to the case descriptions, the Cummings conclude that the public

definition of mental illness is much narrower than that of mental health experts and that they use a different set of criteria in distinguishing between normal and abnormal. There seemed to be quite a sharp cut-off point where behaviour comes to be seen as ill when it becomes both non-normative and unpredictable (1957:105). Another observation which was also mentioned by Star, was that there seemed to be a tendency to 'normalise' certain behaviour with statements such as 'It's just a quirk' and 'It takes all sorts to make a world' (Cumming and Cumming, 1957:109).

Nunnally (1961) was also concerned with information flow to the public and attitude change, with an emphasis on the nature of mental illness and its treatment. His main concern was with what the public thought about causation, treatment and symptoms, the social effects of mental illness and how these ideas develop and change.

The research utilised several survey studies, mostly with an 'opinion panel' of 400 respondents in Central Illinois. The first stage - of interest here - was concerned with the measurement of information held by the general public. 3,000 opinion statements were eventually reduced to 180 and 10 factors emerged from these. The general dimensions of public information were (1) look and act different, (2) will-power, (3) sex distinction, (4) avoidance of morbid thoughts, (5) guidance and rapport, (6) hopelessness, (7) immediate external environment versus personality dynamics, (8) non-seriousness, (9) age function, and (10) organic causes (Nunnally, 1961:17). A revised

Information Questionnaire was obtained using those items which characterised these factors - a total of 50 items. This was administered to a sample of 201 in Knoxville, Tennessee and to 150 in Eugene, Oregon. The first sample of 349 in Illinois was re-scored accordingly. This questionnaire was also mailed to the 'experts' - 150 psychologists and 150 psychiatrists. Nunnally also did a content analysis of the media using these 10 factors as coding categories.

Generally, Nunnally concludes that the information held by the public is not highly structured, nor highly crystallised. He found that the public were often tentative and unsure of their correctness when expressing their opinions and were also often apologetic. But he does state that the 'average man is not grossly misinformed' (1961:22). This was supported by comparing the responses of the experts and the public, which were not extremely different. The only two groups which were found to have inaccurate knowledge were those with less than high school education and those over 50. He found that older people held less accurate information than the younger adults and when education was held constant as a variable, the same relationship held. Nunnally suggests that a plausible explanation for this age difference lies in the different types of education, with younger people being educated with more emphasis on social studies and discussions on matters relating to mental health. He argues that ordinary types of communication programmes, such as found in school classrooms, could be of use in increasing mental health knowledge. Star had suggested earlier that

magazine articles such as 'How psychiatry helped me' or 'Is mental illness curable?' could be useful in this regard and in relation to attitudes. However, Nunnally distinguishes between misinformation and lack of information, saying that although the information which the public has is not 'grossly erroneous', they are probably uninformed. Generally he considers his data on public information as encouraging, but argues that the problem of attitudes is much more complex and discouraging (Nunnally, 1961:29).

In measuring attitudes, Nunnally used a semantic differential rating 'mentally ill person, insane man, nervous breakdown, neurotic woman, mental hospital, psychologist, nurse, psychotherapist' and some related role concepts. His results from this semantic differential study showed that the public regard the mentally ill with 'fear, distrust and dislike' and also as 'relatively worthless, dirty, dangerous, cold, unpredictable, insincere' and so on (1961:46). In addition, 'erratic behaviour and anxiety were regarded by the public as the key signs of mental disorder'. The public did differentiate between neurotics and psychotics, seeing the former as more weak and delicate and the latter as more bad, worthless and unpredictable. It is this factor of unpredictability which, argues Nunnally, 'seems to be a cornerstone of public attitude towards psychotics' (1961:46).

Insofar as the education of the public is concerned here, there are problems. From looking at the items in the media, mental health subjects were portrayed in a less 'correct' way when compared with the general public, the public lying between

the attitudes of the media and of the experts, but closer to the latter. It seemed, considered Nunnally, that the public could possibly discriminate between unrealistic portrayals of such subjects and actual valid serious information (1961:76). This would seem to have implications for the education of the public in a favourable direction.

Further optimism was expressed by Lemkau and Crocetti (1962) who gave three of Star's case descriptions in 1960 to 1,736 adults in Baltimore and on the basis of their results, they suggested that attitudes towards the mentally ill were changing. A larger percentage in their study identified the three cases as mentally ill than did the sample in Star's or Cumming and Cumming's. They use the details this Table illustrates for their argument (Lemkau and Crocetti, 1962:695).

Percentage Identifying Hypothetical Cases as Mentally Ill

Type/Case	National Study (1950) Star	Canadian Town (1951) Cumming & Cumming	Baltimore Study (1960) Lemkau & Crocetti
Paranoid	75	69	91
Simple schizophrenic	34	36	78
Alcoholic	29	25	62

They argue that their respondents seemed to be fairly well informed regarding mental illness and the mentally ill. Expressions of tolerance and understanding were also frequently used. Not only did they ask their respondents to identify which cases were mentally ill, they also asked when such an identification was made, 'Do you think this illness can be cured

or not?' In the case of the schizophrenic, 72% thought it could be cured, 79% thought the paranoid could be cured and 50% thought the same for the alcoholic (Lemkau and Crocetti, 1962:696). They also found a relationship with educational level and family income - the more education or higher income, the more likely the case description would be identified as mentally ill.

In the same vein, Rootman and Lafave (1969) took Lemkau and Crocetti's (1962) study, arguing that the conclusions are difficult to accept initially because of the differences in the communities, as Lemkau and Crocetti had taken not only two communities in different countries but also one in an urban area and the other in a small agricultural rural setting. To investigate this matter further, Rootman and Lafave (1969) compared Cumming and Cumming's (1957) results with their own study of a town of the same population profile in the same province and the same distance from an urban centre. The respondents (N = 102) were asked to rank the desirability of five diseases, mental illness being one, were given the same case descriptions and each was followed by several questions - some to measure enlightenment about mental illness and five social distance items. They found that the percentages identifying the cases as mentally ill were as follows: paranoia - 96%; simple schizophrenia - 67% and alcoholism - 71%, and so they argue that their results support Lemkau and Crocetti's argument that the public's attitudes are changing, although they express this tentatively. They do emphasise an important point

and that is the essential difference between attitudes and behaviour. As they say, a person could not really know if he could let a member of his family marry an ex-mental patient until he was in that situation (1969:264).

Dohrenwend and Chin-Song (1967) reported a similar study done in Washington Heights, New York City, with a cross-section of ethnic groups. They used case descriptions (this time all six that Star used), and again an increase was found in cases considered to be indicative of mental illness. The results compared to Star are (in percentages):

	Star	Dohrenwend and Chin-Song
Paranoid	75	90
Simple schizophrenic	34	67
Alcoholic	29	41
Anxiety neurosis	18	31
Juvenile character disorder	16	41
Compulsive phobic	7	24

However, in comparing Dohrenwend and Chin-Song's (1967) results with those of Star (1955), Kaplan (1972:78) warns that we cannot conclude that the public has adopted a 'psychiatric frame of reference'. After all, as he points out, in the later study only two of the cases were seen as mental illness by a majority of the sample. However, the three cases used by Lemkau and Crocetti (1962) and Rootman and Lafave (1969) were all considered by the majority as indicative of mental illness.

The whole complex area of the relationship among variables such as knowledge, education, age, attitudes and so on does not appear to have been clarified as the research in the area

progresses. Freeman and Kassebaum (1960) in an opinion survey of 483 adults in Washington State, looked at two problems, asking (a) 'Are opinions regarding the etiology and prevention of mental illness related to formal education?' and (b) 'Are opinions regarding the etiology and prevention of mental illness related to knowledge of the technical vocabulary of psychiatry?' (1960:43). Their results showed that there was only a slight relationship between opinions on the aetiology and prevention of mental illness and educational level, and a weak correlation with knowledge of psychiatric technical vocabulary.

Despite these findings Freeman and Kassebaum (1960:47) do say that it should not be accepted that knowledge has little effect on attitudes and opinions to mental illness, but that when education programmes are set up these results should be taken into consideration, especially when in the past the assumption has been that giving people facts automatically results in opinion change.

Altrocchi and Eisdorfer (1961) took as a basis for their research Nunnally's (1961) proposal that 'attitude change may occur as a function of increased information about mental illness, the certainty expressed in a message and through contact with the mentally ill'. To test this in an experimental situation, they gave information about mental illness to a group to explore favourableness in this dimension. They used three groups - 1 class of students in abnormal psychology (N = 14) to which information was given, a control group of students in industrial management (N = 8) where no information was given, and a second control group, a class in personality development (N = 8), a

course with only minor emphasis on mental illness. Again, Nunnally's Information Questionnaire was given, plus six case descriptions. The results were compared to those of a group of five clinical psychologists. However, Altrocchi and Eisdorfer (1961) found no support for the hypothesis that an increase in information results in favourable attitude change. The experimental group showed no more significant change than the control group.

Two other studies were conducted. In the second, the same semantic differential was given to six groups of senior nursing students (N = 75) in a 12-week intensive course in psychiatric nursing. A third study involved a group of senior nursing students (N = 48) before and after psychiatric nursing training. They were given the same six case descriptions plus a description of a healthy person. These second and third groups did show a significant change in a favourable direction. Altrocchi and Eisdorfer (1961) argue that as the results of the initial Information Questionnaire demonstrated a high initial level of information regarding mental illness, and that as Nunnally (1961) demonstrated that favourable change occurs in subjects with initial low levels of information, then it is possible that in cases with subjects with higher education and information (as in Altrocchi and Eisdorfer's students) then attitude change could be precipitated by such things as 'intensive experiential training', as the results of the second and third studies would imply.

Trute and Loewen (1978) took up the problem of contact with

the mentally ill as it relates to attitudes, in a study of 62 adults in Winnipeg. They used an experience scale - such as knowledge of someone who has been in a psychiatric hospital, worked with someone, any close friends been in hospital and visited a patient in a psychiatric hospital. A social rejection scale was used with two main factors - (a) rejection in social relationships, and (b) rejection in social responsibility (similar to those used by Cumming and Cumming, and Elinson et al). Factor (a) included marrying an ex-patient, ex-patient as resident in your area, providing room and board for an ex-patient, member of family dating an ex-patient, group of ex-patients renting/buying apartment/house in your area, falling in love with ex-patient, ex-patient buying house next door. Factor (b) included having ex-patient as manager, ex-patient taking part in community functions, working in same job as an ex-patient, renting apartment to an ex-patient (1978:81).

Trute and Loewen found that when the subjects were classified as 'high', 'moderate' and 'low' groups with experience of the mentally ill, there was a significant difference in rejection. The more personal experience, the more favourable the response on both the social relationship and social responsibility scales, although there was a greater influence on the latter (1978:81). They argue that their results, in the light of the failure of the research on educational programmes to effect changes, indicate that direct exposure could have a greater impact in changing attitudes to the mentally ill.

Despite the great variety of studies in this area in the

United States and Canada, there seems to be a lack of the literature in Great Britain. Maclean (1968 and 1969) reported a study conducted in Edinburgh comparing the views of psychiatrists and the public, on attitudes towards mental illness and the mentally ill, opinions on the causes, course and prospects of cure of mental illness. She used a structured questionnaire with responses to a set of 47 opinion and attitude statements given to 500 adults with 373 returns. These were compared to the responses of 12 teachers of psychiatry. She found that the public tended to be less definite in their opinions, and less hopeful regarding cure. Opinions on aetiology tended to stress pressure of work, job worries, financial difficulties, stresses and strains - environmental factors external to the individual. A holiday or a rest were seen as factors which could avert the risk of a breakdown. Again, it was found that the younger and better educated held ideas closer to those of the psychiatrists (Maclean, 1968:214). She also found one-third considered the mentally ill as a danger to the community, but that 60% had recently acquired information on the subject of mental illness - with TV as the main source. 41% said they had visited a mental hospital in the past 10 years and 6% volunteered that they had been mentally ill (1969:46).

In a social distance scale, 77% agreed that an ex-patient could be a workmate; 64% a next door neighbour; 39% an important or responsible person; 26% a teacher; 50% a district nurse; and 21% a family member through marriage. She also found that the tendency to regard the mentally ill as dangerous or

unpredictable and unreliable was not modified by personal experience, and concludes that many traces of the old stereotypes still persist (1969:50).

However, Maclean did state that the public were generally familiar with the subject and were willing to discuss it openly. Although there was a feeling against a very close association with ex-patients, they were considered as acceptable in more distant, that is, non-intimate roles.

In a recent interesting study, Townsend (1978) using data from German and American high school students, mental patients and mental hospital staff, explored several propositions relating to a social role approach to mental illness. Only some of his results will be mentioned here, although the application of his data as he discusses it would seem to have important implications both theoretical and practical. His first aim was to look at the intercultural differences in popular (and professional) conceptions of mental disorders, which, he argues, exceeds intracultural differences. He measured popular conceptions of mental illness with a sample of high school students in Seattle (N = 728) and Frankfurt (N = 552) (Townsend, 1978:3). Professional concepts were measured with samples of mental hospital staff in various parts of Germany (N = 102) and with staff in Southern California and up-state New York (N = 79).

Townsend (1978) used Nunnally's Information Questionnaire and found that the professionals in each country resembled the public in their own country more than they resembled each other. He also found that the American view stressed Factor 1 -

'Environmental Forces and Personal Effort' - which included very broad general conceptions of mental disorder, stressing the importance of environmental factors, both in causing and curing mental illness - providing a holiday, a change of scene, financial support can help. To get well they considered a person should 'try' and so on (1978:6). This is similar to Nunnally's results (and would also appear to be quite similar to those found by Maclean). Townsend, like Nunnally and others, found that the public conceptions were not highly structured.

However, in Germany, environmental factors and personal effort were not seen as important. There, there seemed to be a dichotomy, both in the minds of the public and the professionals, between environmentally induced mental illnesses - which are seen as transitory and curable, and those that are seen as endogenous, chronic and determinate. Townsend (1978) explains the cultural differences by looking at the basic American values of self-reliance, personal effort and environmental influences. These, he argues, are reflected in their conceptions of mental health.

Perhaps most interestingly, Townsend (1978) goes on to discuss the importance of cultural stereotypes for the defining of illness, treatment and the impact on patient self-perception, behaviour and coping tactics. It would seem that it is this wider accumulation of different aspects of information and attitudes, and the consideration of these in the treatment setting which will lead to an understanding of the actual impact of public attitudes towards mental disorder.

However, the issue of changing attitudes towards mental illness and the acceptance of the mentally ill remains contentious. In a series of articles (Brockman and D'Arcy, 1978; D'Arcy and Brockman, 1976 and 1977; D'Arcy, 1981) the discrepancies in the literature in this area are discussed. They contrast Rabkin's (1974) conclusions that, although by then there was apparently less rejection of the mentally ill than in the initial studies, public attitudes were still predominantly negative with Crocetti et al (1971) who found evidence of significantly more favourable attitudes towards the mentally ill.

Three major issues of interest here emerge from these articles and those discussed above - (a) have attitudes changed? (b) do these 'changes' reflect methodological differences? (c) what is the relationship between identification of mental illness and acceptance or rejection of the mentally ill?

The evidence on this first point does not appear to be conclusive. As can be seen from the above discussion, some studies in the 1960s indicated that attitudes had in fact changed, moving towards a view approximating that of the psychiatric profession (cf. Lemkau and Crocetti, 1962; Dohrenwend and Chin-Song, 1967; Rootman and Lafave, 1969). Other research during the 1960s and early 1970s indicated that the public still tended to reject the 'mentally ill' on a similar basis to those in earlier studies (cf. Phillips, 1963; Maclean, 1967 and 1969; Rabkin, 1972 and 1974). Kaplan (1972:78) in reviewing the literature considered that

> we cannot conclude that the public has adopted a psychiatric frame of reference.

More recent studies provide conflicting evidence on the issue of changing attitudes. Cockerham (1981), for example, reports a study by himself and colleagues conducted in 1979 on community attitudes in Urbana-Champaign - where Nunnally's research was conducted. They took 212 respondents with similar social backgrounds to those studied by Nunnally and concluded that in contrast to the earlier study attitudes were quite tolerant. There was also little in the way of 'social distancing'.

D'Arcy, Brockman and colleagues conducted a study in 1974 in Blackfoot and Deerville - the communities studied by the Cummings' in the 1950s - using an interview schedule with the items developed by Star and also used by the Cummings'. Their results indicated less change over time than might have been expected and showed similarities to those of the Cummings' both in terms of social distance and identification of mental illness.

Brockman et al (1979) and D'Arcy (1981) point out that some of the discrepancies between studies may be explained by methodological differences. They argue, for example, that close-ended interviews, used in many of the post-1960 studies, tend to produce more positive results. McPherson and Cocks (1983) on the basis of Brockman et al's (1979) suggestion that such result divergence may be because of methods used, compared attitudes using a split-half sampling method with a social distance questionnaire and an interview. From their results they argue that some, although not all, of the variation could be due to methods used.

D'Arcy (1981) also considers the problematic use of 'mental

illness'. His subjects were asked both to identify the vignettes as 'mentally ill' and 'something wrong', and he points to the findings that a wide range of behaviours were identified as 'something wrong' in both the Cummings' original study and in the 1974 study.

The results are as follows (D'Arcy, 1981:104).

	'Something wrong' (per cent)		'Mentally ill' (per cent)	
	1951	1974	1951	1974
Paranoid schizophrenic	91	94	69	70
Simple schizophrenic	70	70	36	34
Alcoholic	60	85	25	25
Anxiety neurotic	55	48	20	9
Compulsive phobic	28	14	4	3
Juvenile character disorder	83	55	4	11

This problem was also noted by Clausen and Huffine (1975) who point to the variation in studies with vignettes in the use of these alternatives. Lemkau and Crocetti's (1962) results, for example, may reflect their use of 'some kind of mental illness' in relation to the vignettes.

Another problem with the meaning of the identification of behaviours as mental illness is the association with acceptance or rejection of the mentally ill. The assumption behind many of these studies on changing attitudes is that an increase in recognising behaviour in vignettes as mental illness reflects a move towards the view of the psychiatric profession and therefore by implication more understanding and more tolerance. However, identifying behaviours in this way could also have negative connotations. Among others, Roman and Floyd (1981) and

D'Arcy (1981) point to these different interpretations.

Phillips (1966) found that identifying behaviour as mental illness was associated with rejection and not acceptance of the mentally ill. Bentz and Edgerton (1971), in a test of this issue, interviewed 1,405 respondents and compared the results from a social distance scale with responses to vignettes. In terms of acceptance, they found no difference between those identifying the vignettes as mental illness and those who did not. They argue that overall their respondents were generally accepting (with the exception of hypothetical personal relationships) and question the assumption that labelling a person mentally ill results in rejection. D'Arcy (1981), however, argues the opposite on the basis of his findings which showed an association between identifying and rejection.

Nieradzik and Cochrane's (1985) hypothesised that deviant behaviour might be tolerated more if an alternative role to 'mental illness' is offered to the public responding to vignettes and social distance scales. They found that the public did hold rejecting attitudes towards the mentally ill, but that if an alternative label of 'gifted painter' was offered then rejection was less. From this they say that public attitudes may be more flexible than is usually thought and that if information is available on what the person's usual role was, this will be focussed on as well as the status of 'mentally ill'. Therefore, in real life, people may be more accepting. They also found some rejection where the label 'mental illness' was given than where the behaviour was presented without the label and consider that attitudes are influenced by both the label and the behaviour.

Alternative techniques have been employed by other researchers. Recent findings, however, indicate that some attitudes are highly stereotyped. But what this stereotype incorporates is not clear. For example, O'Mahony (1979) took up the problem of the use of the term 'mentally ill' in attitudinal studies and substituted the terms 'neurotic people', 'mental patients', 'insane people', to see how people differentiated on those dimensions. With a sample (N = 400) of the Irish public, he gave an adjective stereotype checklist (Stereotype Measure) with 50 adjectives and asked the respondents to check as many items as they wanted against 'neurotic people', 'mental patients', 'insane people' and 'doctor' (as a control). The respondents were then asked to look over the adjectives chosen and place the five most applicable to each category. The stereotypes which emerged were: neurotic people - worrier, moody; insane people - tormented, sick, unbalanced; mental patient - depressed, confused, disturbed, unfortunate (O'Mahony, 1979:99).

In his discussion, O'Mahony argues that although these three categories give rise to distinct stereotypes, the most stereotyped category was 'mental patient' and he argues that this is probably a reflection of the old stereotype of the mental patient. Walkey et al (1981) using a similar technique with students in New Zealand, found similar results. In this study there was a strongly negative stereotyped bias with 'mental patient' and 'insane people' but less negative responses with 'ex-mental patient'. Walkey et al (1981) in arguing that attitudes have changed very little since the Cummings' study warn of the

implications for success and acceptance in community care programmes.

Jones and Cochrane (1981) also using a semantic differential found a clear stereotype of mental illness. However, patients in this study were identified as 'withdrawn, intolerant, unsophisticated, perplexed, emotional, tense, irritable, irrational, suspicious, suicidal and undependable' (some of these terms being associated with either male or female patients, others with both). They also argue that this stereotype reflects reality in that it corresponded to a patient symptom list. O'Mahony (1979) also concluded that mental patients seemed to be described by traits which would be associated with conditions which would in fact be likely of people admitted to hospital.

Overall, the research indicates considerable ambiguity about what the stereotype of mental illness is and what this means to the issue of illness identification (as well as to those defined as mentally ill).

Goldstein (1979) concludes from the literature that there is a cultural stereotype of mental illness which has existed over time; but this is a gross stereotype based on bizarre and/or threatening behaviour. Gove (1970 and 1979), however, has pointed out the problem of the association between a well established and reinforced stereotype and the diverse nature of residual deviance. Goldstein (1979) agrees that this is problematic. Several authors point out that (among others Gove, 1970, 1979, 1982b; Townsend, 1978; Huffine and Clausen, 1979; Cockerham, 1981) in practice, as the stereotype of mental illness is so extreme,

people will be reluctant to apply the label to others (or to themselves).

The studies which use 'vignettes' generally ask if a certain type of behaviour is indicative of mental illness. Not attaching this label is taken as indicating a high threshold level of recognising mental illness. Townsend (1978) argues that it is not surprising that this threshold is high because it is the stereotype of mental illness which is used by the public in recognising and defining mental illness. This, he says, is supported in the literature both on attitudes, where the most extreme 'vignettes' are seen as ill, and in the literature on denial in the family. In general it seems that if behaviour is not close to the stereotype then it will not be considered 'mental illness'.

In fact there is some evidence that people are not only reluctant to apply the label in defining someone as ill but also when people are hospitalised. Rabkin (1979), for example, found that a person was not automatically labelled as a result of being in a psychiatric hospital. She concluded that the label was applied, by both the public and professionals, with much more restraint than is suggested by other studies.

However there is some reason to think that, although the public may think of 'mental illness' in terms of a stereotype, their views on disorder may be much broader. Scheff (1963 and 1966) initially argued that the public's view of mental illness is developed partly from exposure to medical conceptions and partly from stereotypes of mental illness. Drawing from

Nunnally (1961), he continues, the public view lies between those of the experts and what is portrayed in the media. To some extent this stereotype will have been replaced by a medical concept but not eradicated.

Koldjeski (1974) in an empirical test of Scheff's hypothesis with three groups of students found that they did in fact hold both medical conceptions and stereotypes of mental illness.

Townsend's (1978) respondents, on the other hand, tended to reject stereotypes of the mentally ill but they did use conceptions of mental illness. This distinction between conceptions and stereotypes may explain some of the confusion regarding the nature of the mental illness stereotype and its correspondence to reality.

Other research shows that some people adhere to stereotypes of mental illness while others think of it in much less extreme ways. Rabkin (1979) found some evidence which supported that of Askenasy (1974) that there were two attitudinal clusters among respondents - those who exhibited a 'cluster of intolerance' and a 'cluster of tolerance'. Rabkin concludes:

> The former tend to perceive former mental patients as dangerous, untrustworthy, qualitatively different from other people, occupationally limited, probably incurable, and always at risk of relapse. In contrast, another subgroup of his respondents regarded former mental patients as indistinguishable from the rest of the community in all these respects. My similar findings lend support to the validity of these separate attitudinal clusters as Askenasy has defined them.

Askenasy (1974) also found in his survey of public attitudes that there was an intermediate step in between what is thought of

as mental illness and normal - this, he says, corresponds to the popular idea of 'nervous breakdown'. A large majority of the public considered there was a difference between mental illness and nervous breakdown. Only a few thought of it as a polite term for mental illness. He argues therefore that this does not agree with early studies (those using vignettes) such as Star's and the Cummings', who thought that when behaviours were not labelled as mental illness (that is extreme behaviours), they were thought to be more or less normal. Askenasy argues that a cognitive and attitudinal distinction was made between the two terms:

> Nervous breakdown is perceived by the respondents as a disturbance due to environmental pressure, which is temporary and curable and may require a short hospitalisation. Mental illness, on the other hand, is generally considered to be incurable, an unchanging component of personality requiring long hospitalisation and affecting all spheres of functioning as in the most extreme forms of psychosis.
> (Askenasy, 1974:275)

Other examples of 'intermediate' disorders were found by Dinham (1977). In his study in outport Newfoundland the label 'nerves' tended to be used as a justification for not identifying a person as mentally ill. He also found some overlap between the two terms but 'nerves' was not considered to be a serious condition.

Findings such as these support the conclusions from the vignette studies discussed above where there was a much broader recognition of 'something wrong' than of 'mentally ill' with the behaviour descriptions.

Another question concerning stereotypes of mental illness is whether they exist as culturally specific or cross-culturally. This question in turn relates to the issue of the universality of psychiatric disorder, which is beyond the scope of this review. However, a few points of interest arising from the literature will be mentioned here.

As a labelling perspective points to the societal reaction to and definition of mental illness, it stresses cultural factors. Scheff (1966) initially argued that stereotypes are learned in childhood and that all members of a society share this stereotype. Townsend's (1978) respondents did not use a stereotype of mental illness but they did employ 'conceptions'. Townsend found greater differences in these conceptions between cultures (German and American) than within. Cultural specificity was also argued by O'Mahony (1979), although his position was supported in terms of attitudes rather than stereotypes per se.

That the stereotype exists across cultures is supported by Jones and Cochrane's (1981) findings. The stereotype endorsed by their respondents was measured in England and this corresponded closely to the patient symptom list which was compiled in the US (Zigler and Phillips, 1961). It may be of course that a stereotype of mental illness is not restricted to one country but among those sharing the same language and other cultural factors. If in addition the media plays a major part in reinforcing such stereotypes then it would seem likely that geographical boundaries would be transcended.

Conclusions about the cultural specificity of a mental illness

stereotype also depend on what we assess this stereotype to be. As can be seen from the above discussion, this is not clear. However, the majority of the literature agrees that, as Nunnally (1961) found, unpredictability is a common theme. Horwitz (1982) in fact argues that behaviours which are considered to be incomprehensible are defined as mental illness in all societies. (However he emphasises that this does not mean that psychosis exists universally.) Most societies, he says, distinguish two types of mental illness - non-violent eccentricities and violent types of madness. Both are seen as incomprehensible and hence as mental illness. Horwitz (1982) argues that it is not surprising that stereotypes are based on incomprehensibility and unpredictability as they arise from the requirements of social interaction.

A final issue regarding stereotypes is the role of the media in their transmission. Nunnally (1961) and Scheff (1963 and 1966) argued that a stereotypical image of the mentally ill is presented in the media. Scheff (1966) argues that these stereotypes, like most stereotypes, are learned in early childhood and are reinforced in everyday jokes and conversations and in media presentations. However, whether the public accepts such stereotypes as realistic is questionable. Nunnally (1961:76) in finding that the public's view on mental illness lay between those of experts and those portrayed in the media, but closer to the former, suggested that the public is indeed able to discriminate between unrealistic portrayals and valid information.

In addition, since these early studies major changes have

taken place, which it might be expected, would have influenced public views. These include the anti-psychiatry movement, the growth of community care, or at least an ideology of community care, and the deinstitutionalisation movement.

Recent analyses of media presentations find less stereotyping than did the early studies. Linter (1979) pointed to sensationalism in the media. However, Winick (1982) in surveying the media, argues that Nunnally's conclusions would be less valid today. He surveyed American newspapers, magazines, comic books, fiction, self-help books, accounts of celebrities as mentally ill, television and radio. He found evidence of stereotyping in jokes, on occasion in newspapers and television but more realistic portrayals of the mentally ill in other media. A particular contrast was found between films made prior to and after 1968.

If the media both influence and reflects public views this would lead us to expect more liberal and positive attitudes than was found in the early studies. It would also seem, however, that stereotypes are persistent and remain in the public consciousness.

Patient self-conceptions and attitudes towards mental illness and hospitalisation

The labelling perspective, as advanced by Scheff (1966) assumes that (a) a person will accept a deviant identity, once labelled, and (b) this identity will be stigmatised. As was mentioned above, patients' own views have not been central to the debate surrounding the labelling perspective and mental illness.

Some writers have pointed out that this is surprising given the perspective's roots in symbolic interactionism (Rotenberg, 1974; Weinstein, 1983). This section is concerned with issues surrounding the patients' acceptance or not of the 'mental illness' identity. The problem of stigma will be discussed below.

Among others, Rotenberg (1974) has questioned the automatic acceptance of a deviant identity and questions if the labelling perspective is so powerful that by naming a person deviant he will become so, and also if this is reversible. He points to the evidence from Sykes and Matza (1957) where delinquents use techniques to neutralise deviant self-images. In fact the deviancy literature is full of examples of the ways in which those 'labelled' deviant will reject such labels or deal with them in other ways. Stokes and Hewitt (1976) refer to the techniques people use in problematic situations as 'aligning actions' - drawing from a number of writers including Goffman (1961). Plummer (1979) also discussed the different ways which people dealt with deviant labels.

The overly passive view of deviants in general is also taken up by Rogers and Buffalo (1974) who point out that techniques of 'fighting back' have been neglected. They draw example from the deviancy literature and formulate a typology of nine such adaptations. These are: acquiescence, repudiation, flight, channelling, evasion, modification, reinterpretation, redefinition and alteration.

In fact the literature on psychiatric patients provides conflicting evidence regarding a labelling perspective. Some of

this finds that patients do not always accept the mental illness label. Others find that such acceptance is related to length of stay or outcome.

Kennard (1974) used a semantic differential, with patients newly admitted to hospital and the person closest to these patients, with the concepts of 'myself at the moment, myself as I would like to be, a mentally ill person' (the patient at the moment, the patient as I would like to be, a mentally ill person). He found that patients viewed themselves closer to an ideal than to a 'mentally ill person'. He also found divergence between what the patients thought of themselves and how the close others saw them. Patients saw themselves as less ill, both physically and mentally, than the others did. Kennard (1974) considers that this divergence can indicate both a lack of insight on the part of the patient and scapegoating by others.

Kennard and Clemmey (1976) argue that their findings based on an investigation of changes between admission and discharge in how patients perceived themselves, tend to give some support to a labelling perspective. These perceptions were measured on a semantic differential scale using the concepts of present self, usual self, ideal self and 'most mentally ill people'.

To examine the argument based on a societal reaction perspective that people identifying with the role of the mentally ill would stay in hospital for a lengthy period of time, Kennard and Clemmey (1976) compared the relationship between length of stay and the 'self' and 'most mentally ill people' concepts.

They found that patients who stayed in hospital under two weeks and those whose stay was relatively long perceived themselves as closer to 'most mentally ill people' than those who stayed for an intermediate time.

It would appear at first that these results do not necessarily support a labelling perspective. However, Kennard and Clemmey (1976) argue that when schizophrenic patients are excluded from the analysis (those being found to both see themselves negatively and stay in hospital for a relatively short time) then there was some support for their hypothesis based on a societal reaction perspective. Identifying with mental illness tended to be associated with longer stays in hospital.

Such complexity is also indicated by Doherty (1975). In his investigation of 43 patients, three groups emerged. One group initially denied the mental illness label and continued to do so. The other two groups initially agreed that they were mentally ill (when asked directly), one continuing to do so and the other subsequently denying it. Those who initially accepted the label but then gave it up stayed in hospital as long as those who denied it but shorter than those who continued to accept the label. They were also rated by the staff as becoming healthier over time. Doherty (1975) generally argues that his findings indicate the problem is not as simple than can be explained by either the labelling or the medical/clinical perspective. However, he continues, what is clear is that initial acceptance of the mental illness label did not necessarily adversely affect these patients' conditions or behaviours.

Townsend (1978) hypothesised that, like the American and German publics and mental hospital staff, mental patients would have similar conceptions of mental illness; that is the Americans would adhere more to the view that environment and personal effort play an important part in mental illness, while German patients would lay more stress on biological perspectives. His data supported this (1978:26).

From this Townsend also hypothesised that patients' coping tactics would also reflect these conceptions, that Americans would support the idea that release from hospital depends more on adjustment and personal effort, whereas release for the Germans depends on the illness being 'cured'. Patient interview schedules were used with 82 German patients in a state hospital near Frankfurt, and 98 American patients in a California state mental hospital. These were to explore their conceptions of mental illness, their perceptions of coping tactics and their self-conceptions. He found that patients did not use stereotypes of insanity in discussing the reasons for a person being admitted to a hospital. They also tended to deny that they were mentally ill and did not identify with those they considered as mentally ill. (Stereotypes in this study were not used either by the students or the staff.) Townsend argues therefore that his findings do not support Scheff's application of labelling theory in this area.

As the evidence suggests that the common stereotypes of violence and delusional personalities are not commonly reflected in reality, and Townsend argues there seems to be no coherent

folk model in urban populations of mental illness, he argues a distinction should be made between stereotypes and popular conceptions. It may be, he concludes, that the stereotypes which Scheff discusses and which are portrayed in the media do not structure symptomatology as theorised by Scheff, but that conceptions as outlined above do influence both patient beliefs and coping tactics, and perhaps influence symptomatology too.

O'Mahony (1982) also investigated the issue of patient denial but interprets his results in a way which appears to account for some of the discrepancies in this area. He used a semantic differential scale with 50 first admission patients' concepts of 'present self', 'usual self' and 'the mentally ill' and 19 psychiatrists' and 72 nurses' concepts of 'the mentally ill'. He found that patients did share a stereotype of the mentally ill with the psychiatric staff but did not perceive themselves in terms of this stereotype.

O'Mahony (1982) considers three perspectives on the problem of patient denial. The first - a medical/clinical perspective - sees such denial as harmful because it assumes 'a failure to grasp reality'. The second - sociological - based on the labelling perspective, considers denial as beneficial because of the assumed negative consequences of being labelled mentally ill. The third perspective, which he proposes as a useful explanation for the extent to which patient denial exists, given the evidence from other research, he calls a 'normal psychological process'. This views denial (of a highly stereotyped concept of mental illness) as normal. He argues that earlier studies found that:

> Alcoholics and stutterers do not identify themselves with their own stereotype of the alcoholic and the stutterer. A similar phenomenon has been demonstrated in the present study in the case of first admission psychiatric patients. The patients hold, in common with psychiatric professionals, a distinct, well defined, negative concept of 'the mentally ill', but on the whole, do not characterise themselves in terms of this concept.
> (O'Mahony, 1982:116)

He concludes that denial of the stereotype does not prevent entry into a patient role. His findings indicated that these patients did think there was something wrong with their present condition. He argues that his results are not consistent either with the sociological (labelling) perspective or with the medical/psychiatric perspective, but rather indicate this 'normal psychological process'.

Meile and Whitt (1981) in their comparison of sick role theory and the labelling perspective found that contrary to the former view, patients thought of mental illness negatively. On the other hand they thought of their own illness positively. In another paper Meile (1986) reports that patients did view their own problems more negatively than the public viewed theirs, but neither thought of their own problems as 'wrong'. They also perceived them as 'natural'.

Other researchers, such as Toews et al (1984) also found that both committed and voluntary patients indicated that they had preserved a positive self-image.

Weinstein (1983) in a review of 35 studies of patient attitudes concludes that although patients think of mental illness negatively

and hold a stereotype of mental illness, they did not think of themselves in this way - that is they did not internalise this imagery. The fact that they recognised a stereotype he takes to lend support to a labelling perspective. That they did not identify with this, he considers to refute such a perspective.

Goffman (1961) describes different types of patient adaptation to the psychiatric hospital. These are 'situational withdrawal', 'intransigence' (refusing to co-operate), 'colonisation' (using experience of the outside world to emphasise the desirability of life inside) and 'conversion' (the taking of the hospital's view of oneself). Goffman says that most inmates:

> Adopt a somewhat opportunistic combination of secondary adjustments, conversion, colonisation, and loyalty to the inmate group, so that the inmate will have a maximum chance, in the particular circumstances, of eventually getting out physically and psychologically undamaged. (Goffman, 1961:64)

Cockerham (1981) argues that given the evidence in the literature which indicates that patients do not always think of themselves as mentally ill, then 'conversion' is less likely to be in terms of an acceptance of the hospital's view of oneself as 'an acceptance of hospital life and the status of mental patient' (1981:283). Townsend (1976 and 1978) points out that Goffman did not state explicitly that patients come to see themselves as mentally ill, only that they accept 'the hospital's view'. He argues that individuals may present themselves as mentally ill but also deny that they are such.

Although numerous attacks on labelling theory have somehow

assumed the automatic acceptance of a deviant identity, Goldstein (1979) points out that even in Scheff's initial formulation the issue of the transition from being labelled to the acceptance of self as mentally ill is ambiguous.

Plummer (1979) argues that two versions of a labelling perspective may be advanced. The first, similar to Scheff's (1966) formulation is that:

> labelling initiates and amplifies deviance - it has negative consequences; labels are deterministically internalised by labelees; and such labels are irrevocable.
> (Plummer, 1979:118)

He argues that Scheff's (1966) formulation was closest to a crude deterministic model of labelling. This has been described by Akers (1968:463) as:

> One sometimes gets the impression from reading the literature that people go about minding their own business and then - 'wham' - bad society come along and slaps them with a stigmatised label. Forced into the role of the deviant the individual has little choice but to be deviant.

(Akers admits this is an exaggeration; he also considers that, toned down, this is labelling theory's major contribution.)

Plummer (1979) points out that those who set out to 'test' labelling theory usually take a narrow view of the perspective. A wider version would be:

> labels may prevent (deter) or change deviance - they may also have 'positive' consequences; labels may be voluntarily avowed and disavowed, and responded to in a variety of ways; labels may be reversible and changeable; destigmatisation is possible.
> (Plummer, 1979:118)

Whether or not acceptance or rejection of the mental illness label is taken to support one perspective or another may depend on the definition of the labelling perspective adopted. If a 'broader' view is taken, as Plummer (1979) suggests, then such a view can accommodate different interpretations.

It may also be that some patients are more inclined to reject the label than others. Rogers and Buffalo (1974) point out that adaptation modes may vary depending on individual and social dimensions. They consider that such modes might vary depending on the type of behaviour concerned and that there may be movement across these types of adaptation.

A final point concerns the use of 'mental illness'. Identification with this term or with 'mentally ill person' is central to the research in this area. As was seen above, findings of rejection or acceptance of this term have been taken as evidence to support the labelling, psychiatric and/or sick role perspectives. However, it seems likely that people interpret this concept in different ways. Doherty (1975) considers that this might have been problematic in his study. This, as was discussed above, is also central to the issue of recognising psychiatric disorder. As those attitudinal studies seem to show, 'mental illness' is associated with a stereotype, it is not surprising, as O'Mahony (1982) points out, that people would reject this label. As in the research on public attitudes, it would seem likely that patients, while rejecting the mental illness label, may also recognise a broad range of psychiatric disorder. They may therefore both see themselves

as ill while simultaneously rejecting the label.

Goffman's (1961) description of life in total institutions - Asylums - was one of the influential works pointing to the harmful effects of the psychiatric hospital. The 1960s and 1970s saw the period of deinstitutionalisation and the anti-psychiatric movement. Writers such as Barton (1959) coined the term 'institutional neurosis' in his book of the same name. Szasz (1971), Laing (cf. Boyers and Orrill, 1972) and others criticised psychiatry. All of this influenced policies regarding the commitment and treatment of psychiatric patients.

However, as in the issue of patients' self-conceptions, the views of patients themselves have not always been considered in relation to the experience of hospitalisation. In the 'debate' between the labelling and psychiatric perspectives, this stance may have been ignored, as was mentioned above, because of the focus on societal reaction. There may be other reasons why patients' own views have not been considered. Weinstein (1983) argues that this is partly because of a belief that patients' views are unreliable or invalid. The quantitative studies which do exist, he thinks, have been ignored in favour of more subjective qualitative studies which have stressed negative aspects of hospitalisation and which have been taken to coincide with and/or support a labelling perspective. These he criticises by arguing that the observer or even the 'pseudopatient' stance is problematic simply because the observers are not ill and could not experience the situation in the same way as someone who was distressed. Weinstein (1981) points out that both Goffman (1961)

and Rosenhan (1973) admitted this as a problem.

There is evidence that patients do not view hospitalisation as negatively as a labelling perspective would imply. Linn (1969) found a large group of patients who regarded hospitalisation favourably. Kahn et al (1979) found that patients were not nearly as negative as the staff considered them to be.

From an analysis of the quantitative studies which have been done, Weinstein (1972, 1981 and 1982) argues that patients tended to view hospitalisation favourably. Generally they considered it was helpful, non-restrictive and non-stigmatising. The main criticisms by patients were staff's permissiveness and dominance and patient freedoms and responsibilities. He did find some differences - in three out of five studies - in patients' favourableness towards hospitalisation between patients on 'better' wards, that is unlocked with high release rates and low drop-out rates (Weinstein, 1981:310).

In another paper, Weinstein (1983) reviewed 35 studies relating to patient attitudes and considered the applicability of labelling theory. Within the general context of this theory, he considers five propositions. These, derived from various points made by Goffman (1961), Becker (1963), Phillips (1963), Scheff (1966) were as follows:

(1) Hospitalised patients tend to espouse unfavourable attitudes towards mental illness

(2) Patient attitudes toward mental illness become more unfavourable during the course of hospitalisation

(3) Patients are less favourable in attitude towards mental illness than non-patients

(4) Ex-patients tend to express unfavourable attitudes towards the stigma of mental hospitalisation

(5) Ex-patients' attitudes towards the stigma of mental hospitalisation, compared to their pre-discharge attitudes, will be more favourable.
(Weinstein, 1983:72-73)

From an analysis of the 35 studies, he claimed that labelling theory was not supported on the basis of these propositions although some data supported some aspects of such a theory.

Support for labelling theory was found in that 84% of patients' responses indicated they had learned a negative stereotype of mental illness and many former patients felt they had been stigmatised. However, as in his earlier studies, Weinstein (1983) points to predominantly favourable attitudes.

While attitudes overall may be more positive than some of the early literature suggests, it may be that satisfaction or dissatisfaction is related not only to conditions in hospitals but also to expectations of hospitalisation and the understanding of and willingness to accept the patient role.

Mechanic (1978:417) outlines the expectations associated with the sick role, as formulated by Parsons, in the following way:

(1) the sick are allowed exemption from social role responsibilities

(2) the sick person is also exempted from responsibility for his condition and that he is not usually expected to be able to get well by his own decision or will

(3) the patient is expected to want to get well

(4) he is expected to seek technically competent help and to co-operate with the helper in trying to get well.

Mechanic (1978) points out that this is an ideal-type and does not necessarily reflect reality. Basically, however, the patient is expected to be to some extent passive, dependent and not personally responsible.

The applicability to all situations of the sick role as formulated by Parsons (1951) has been questioned, particularly with respect to psychiatry (Denzin and Spitzer, 1966). As Sobel and Ingalls (1968) point out, these are generally not considered to be desirable behaviours for the psychiatric patient. They conducted research with psychiatrists, psychiatric patients, physicians, surgeons, medical patients and surgical patients - a total of 588 subjects - in an attempt to examine the psychiatric compared to the medical sick role. They found that psychiatric patients perceived their role as closer to that of the medical patient than did the psychiatrists. The psychiatrists perceived the patient role as characterised by 'independence, activity and self-direction in the treatment situation' (Sobel and Ingalls, 1968:332).

The literature in this area generally argues that conflicts may emerge when patients do not share the same definition of the therapeutic situation as the psychiatric staff. Sobel and Ingalls (1968) argue that hidden disparities may result in resistance to psychiatric treatment. Tuckett (1976b:202) asks:

> How does a psychiatrist deal with patients who should be active, in psychotherapy for example, but want just to lie down and have their problems 'whisked away'?

Skodol et al (1980:37) found conflict between

> the patients' need for structure and the staff's preoccupation with democracy.

Ferguson (1974), in a study in the Royal Edinburgh Hospital, found that some first admission patients, who had entered hospital expecting ward organisation to be similar to that in a medical ward, tended to be confused by the permissiveness and democracy on a psychiatric ward.

All of this, of course, takes place within psychiatric practice which itself incorporates a variety of ideologies and therapies. There is a large body of literature which addresses the issues of staff role perception and treatment practices. Rubenstein and Lasswell (1966), for example, discussed a movement from custodial care to dynamic democratic treatment within the psychiatric hospital. A great deal of subsequent research was based on Gilbert and Levinson's (1957) dichotomy of custodialism and humanitarianism. Scheff (1960) classified psychiatric nurses as 'reform', 'conservative' and 'neutral'. Individual staff members it seems have different views on their own and patients' roles. Changes in psychiatry, however, over the past 25 years have meant a growing emphasis on psychotherapy and have seen a reduction in custodial care and restraint. However, the other major dominant therapeutic mode is chemotherapy. Within

this context it is not surprising that the literature indicates uncertainty among patients regarding the patient role.

The research, however, concludes that such disparities and conflicts do not present a problem for all psychiatric patients. Strauss et al (1964) found that what is perceived as therapeutic varies among different patients. Linn (1969) investigated this point and found differing perceptions and attitudes towards hospitalisation among psychiatric patients. He argues against assuming that there is a homogeneous patient view regarding the understanding of hospitalisation. Dowds and Fontana (1977:299), for example, found that patients were quite satisfied with the idea of 'Hospital as Retreat' and suggest that

> Many patients are simply requesting succourance and ventilation, not aid in gaining insight into their problems, when they come to hospital.

Sobel and Ingalls (1968) found some differences between patients in a State hospital, out-patients and those in private practice. The latter group, they found, held a view of their role in much closer agreement to that of the psychiatrists. They hypothesised that these patients, better educated and of higher social status either came to psychotherapy with some knowledge of its behavioural requirements, or - and they think this is more likely - they had subsequently been educated into this as a result of their treatment.

Overall Ferguson (1974) found no significant differences between what his first admissions anticipated and what they found. He considers that this is either because expectations somehow

determine how the actual situation is perceived or that people are more aware of what will happen than is generally presumed.

Of course attitudes to hospitalisation will not only depend on whether or not a patient 'understands' the psychiatric patient role and is willing to accommodate to certain types of therapeutic practice. This assumes a rational sick role perspective which as Meile (1986), citing Freidson (1970) points out, does not take into consideration the issue of stigmatisation. It seems likely, if the mental patient role is considered negatively, that this will have a considerable impact on attitudes towards hospitalisation. This may in turn be influenced by how the individual sees his or her illness, which may be determined by circumstances surrounding the psychiatric admission or vice versa. Linn (1969:462), for example, found that patients were likely to be more negative if family members had made the decision regarding the psychiatric admission than if they, or friends, had been the most important agent. Whitt et al (1979) suggest that labelling theory may focus on people entering treatment against their will but that voluntary admissions may conform more to the illness role model. Their data, however, were not amenable to testing this hypothesis.

In terms of attitudes towards hospitalisation, Weinstein (1972, 1981, 1982 and 1983) is of course particularly concerned to redress the balance which has tended in the past to be critical of the psychiatric hospital and its effects on patients. Some of these criticisms have been responded to in terms of policy changes and, indeed, as Gove (1979) points out, the changes in psychiatry and the psychiatric hospital over the past 25 to 30 years have been

considerable. That is not to say that some of the initial criticisms are still not valid. However, it does seem likely that attitudes are more favourable than the literature supporting a societal reaction perspective would indicate.

Of particular interest here is the fact that the average length of stay in hospital is now quite short. For many patients, this may only be a few days. The shortness of such duration would seem to have some relevance to any argument concerning the meaning of patient acceptance of a definition of self as psychiatrically disordered. Whether or not patients accept the label of 'mental illness' (and the meaning of this is debatable given the problematic usage of the term 'mental illness') it seems unlikely, given the shortness of such duration, that they would automatically enter a deviant career, even if there are stigmatising effects of having been in hospital. In addition, that patients are probably aware that their stay in hospital will likely be short also probably influences the favourableness of their attitudes towards the hospital itself.

The stigma of psychiatric hospitalisation

The studies on rejection or acceptance of the mentally ill have tended to focus on hypothetical questions and, as many researchers have pointed out, actual behaviour towards psychiatric or former psychiatric patients may be considerably more negative. In fact it is commonly assumed that former psychiatric patients may be stigmatised to a greater or lesser

degree.

Societal reaction theorists are particularly concerned to point out the damaging effects of being defined, or labelled, as mentally ill and the implications of having been a patient in a psychiatric hospital, insofar as deviant 'careers' are concerned. Becker (1963), in discussing deviance generally, adopted Hughes' (1945) concepts of 'master status' and 'auxiliary status' traits and argues:

> ... apprehension for one deviant act exposes a person to the likelihood that he will be regarded as deviant or undesirable in other respects.
> (1963:33)

Goffman (1963), in particular, discusses the discrediting effects of others knowing about a history of psychiatric hospitalisation. It is argued that the status of having been a psychiatric patient takes precedence over other statuses. Scheff (1966:87), for example, argues:

> ... the former mental patient, although he is urged to rehabilitate himself in the community, usually finds himself discriminated against in seeking to return to his old status, and on trying to find a new one in the occupational, marital, social and other spheres.

However, just as a patient may choose to accept or reject the mental illness label, former patients may develop strategies for dealing with their problematic identities. Some studies, for example, show that former patients will attempt to hide the fact of their hospitalisation (Yarrow et al. 1955). Goffman (1963:58)

calls such withholding of information as 'passing'.

Goffman (1963:117) also describes a strategy whereby the 'discreditable' person divides the world into those he tells nothing to and a small number to whom he confides all and then relies on. Alternatively the individual can disclose information about himself and thus:

> radically transforming himself from that of an individual with uneasy social situations to manage, from that of a discreditable person to that of a discredited one.
> (Goffman, 1963:123)

Strategies are also available for former patients wishing to justify their hospitalisation or rationalise their illness. For example, several researchers have found that former patients and their families frequently deny that the individual was mentally ill (Schwartz, 1957; Cumming and Cumming, 1968). Cumming and Cumming (1968:410) describe various explanations used by former patients to reverse stigmatisation - what they describe as 'undoing-of-the-loss'. They may:

> (a) redefine hospitalisation as a mistake
>
> (b) redefine themselves as changed or transformed so they are different from the person who became mentally ill
>
> (c) redefine the situation to say that the public is ignorant about people who go into mental hospitals.
>
> (Cumming and Cumming, 1968:415)

Conditions both in and out of psychiatric hospitals have changed considerably from when Goffman (1961, 1963) and Scheff (1966) wrote their influential works on the psychiatric patient,

but some of these changes, particularly the movements towards de-institutionalisation, were influenced partly by these writers. The psychiatric profession itself has been sensitised to the problem of stigma.

Not everyone agrees about the stigmatising effects of having been in a psychiatric hospital. One of Crocetti et al's (1971) conclusions based on their findings of favourable attitudes was that the mentally ill should no longer fear being stigmatised. However, the relationship between stereotypes, attitudes and behaviour is not clear. Nor has the issue been resolved of whether a person is stigmatised because of the label of mental illness or behaviour exhibited. Moreover, the empirical research which directly addresses the question of stigma is neither extensive nor conclusive.

Gove and Fain (1973) examined the experiences of 429 people who had been patients in a state mental hospital to consider whether stigma had had any effect on their social situations. They found that compared to pre-hospitalisation levels there had been an increase in employment and only one respondent said that having been in hospital made obtaining employment difficult. They also report an increase in those who said they had a 'good' or 'excellent' relationship with their spouses and no evidence that other relationships had been adversely affected. Slight improvements were also found in activities outside the home and overall financial situations. When asked directly, most respondents said that their stay in hospital had been beneficial and a few thought it had been harmful. Of the 19 respondents

who said hospitalisation had been detrimental, seven indicated concern about stigma.

Gove and Fain (1973) conclude from this that although the public hold a negative stereotype of the mentally ill and in terms of attitudes indicate that they would discriminate against them, they do not in fact do so. The negative effects of being labelled mentally ill, they consider, have been exaggerated by societal reaction theorists.

Not all evidence is as positive, however, Nuehring (1979) examined feelings of stigma among former state mental hospital patients and whether they were seen by others as a burden. Using a sample of 414 patients discharged from a rural state hospital, he found a 'moderate' degree of perceptions of stigma and also a 'moderately high' perception by others of the former patient as a burden.

Several experimental studies have attempted to examine whether it is the behaviour of the person or the label of mental illness which leads others to discriminate against individuals.

Farina et al (1968) led subjects to believe that a co-worker had been told they were mentally ill although in fact this information had not been given. They found that less time was spent talking to the 'stigmatised' subjects.

In another study (Farina et al. 1971) subjects (who were in fact receiving psychiatric out-patient treatment) were led to believe that the confederates had been told either that they were mental patients or medical-surgical patients. They found that those in the medical-surgical group scored better on a

co-operative task than those in the mental patient group. Some of the former also considered that the confederate over-estimated their contribution to the task whereas the 'mental patients' did not. The latter rated the task as more difficult. The confederates also rated the 'mental patients' as more tense and anxious.

Farina et al's (1968 and 1971) studies basically conclude that if a person believes others think he is stigmatised he will in fact behave in such a way that will bring about rejection.

An experiment by Pollack et al (1976), however, did not support the view that the label itself has a stigmatising effect. They assessed students' perceptions of behaviour in two videotapes and found that attitudes were more affected by the behaviour than the label.

Page (1977), although not dealing directly with the experiences of patients, was concerned to address the extent of discrimination and stigma in the community. People advertising rented accommodation in the two major newspapers in Toronto were contacted by telephone. Some callers said they were about to be discharged from a psychiatric hospital, others that they were calling on behalf of a brother who was in jail and about to leave; another group gave no 'criminal' or 'mental illness' information.

Page (1977) found that a positive response to a request for accommodation was more likely if no reference was made to either being a mental patient or being in jail. They were more than three times as likely to be refused if they said they were about

to leave a psychiatric hospital than if they gave no such information. The effects of implying the criminal status were the same.

In a similar study (Page, 1983) some callers stated they were about to leave a psychiatric hospital and some simulated a speech impediment. A control group was found to be 50% more likely to obtain a positive response from the prospective landlords than either of the two other groups.

A third study again found that callers referring to mental hospitalisation or having either a speech impediment or a dissonant voice were less likely to be offered accommodation.

Page (1983) argues that the former mental patient may be discriminated against and that acceptance of the mentally ill is less than is implied by questionnaire studies. Of interest is that the 'speech impediment' callers were also treated less favourably. Page (1983) thinks that the public may discriminate against any deviant or 'different' behaviour when it is 'safe', for example, over the telephone, to do so.

Conclusion

This review has considered four aspects of the process of becoming a psychiatric patient: (a) pathways to psychiatric care and help seeking behaviour; (b) attitudes to mental illness; (c) patient self perceptions and attitudes; and (d) the stigma attached to mental illness and psychiatric hospitalisation.

The labelling perspective defines hospitalisation as the outcome of an individual being identified by others as being ill and being acted

against by them. Both the sick role and medical perspectives assume a 'rational' view of the individual. The patient is assumed to recognise problems and to seek competent help for these.

The literature on pathways to the psychiatric hospital provides some support for both the labelling and psychiatric/sick role perspectives. It indicates a number of factors which may either deter or facilitate help seeking. These include knowledge of and sophistication about psychiatry, recognition by other people and the type of advice given. Feelings of self reliance and embarrassment or fear of being stigmatised also appear likely to deter help seeking. These latter factors lend support to the labelling perspective.

On the other hand, there is some evidence that significant others neither recognise deviance or illness in family members nor always take exclusionary action on that basis. Such findings provide support for the critics of the labelling perspective.

However, the route to the psychiatric hospital often excludes either problem recognition on the part of the individual or exclusionary action against them. This owes largely to the referral system and to the central role of agencies other than people known to the individual, in particular the family physician. The physician would seem to be significant in defining problems as psychiatric and in referring patients for care.

Two other areas which have been central to the 'debate' are, first, the significance of social as opposed to medical factors, and, second, the presumption of illness and automatic admission to hospital.

Insofar as the evidence relates to the former, it does seem that social factors are influential in decisions about hospitalisation.

However, whether this is an adequate criticism of psychiatric practice is questionable. As was pointed out, most psychiatric practitioners are aware that social factors are influential in a variety of situations. That decisions in general medicine are not based purely on clinical considerations would also be recognised by members of the medical profession. Nevertheless, that social factors are determinant is a crucial point in support of a labelling perspective.

The other central issue in the 'debate' has focussed on the automatic admission of patients to hospital. Some early research did indeed find that people arriving at hospital were assumed to be mentally ill and were admitted without question. Other researchers found conflicting evidence. However, this argument (as all these issues) occurs in the context of changing policies and practices in psychiatry. It seems unlikely that people are automatically admitted to hospital now.

Support, then, for a labelling perspective exists but requires considerable qualification. It seems: that people may take exclusionary action against individuals; that individuals may avoid seeking psychiatric help because of (among other things) embarrassment or a fear of stigma; and that social factors (or contingencies) may be decisive at different stages of the process leading to psychiatric hospitalisation.

Several questions arising from this literature are taken up in this research - principally the extent to which the subjects felt they were coerced into a psychiatric admission and what they considered to be the role played by other individuals and agencies; the subjects' reasons for seeking help and factors which might have deterred help

seeking.

That the labelling and sick role perspectives may both be applicable but in different situations has been suggested. It does seem likely that neither perspective can adequately explain the experience of all persons being admitted to hospital. That of detained patients may well be quite unlike that of informal patients. This point will also be considered below.

The literature on attitudes to mental illness is equally as extensive as that on pathways to psychiatric care and help seeking behaviour. A basic assumption of the labelling perspective is that attitudes to the mentally ill are negative and that there exists a culturally shared stereotype of mental illness. Critics of the labelling perspective have argued that, while attitudes may have been negative in the past, they have in fact changed in a positive direction and that people should not fear negative repercussions as a result of seeking psychiatric help. However, it is questionable whether attitudes have changed significantly over the past 35 years. Compared to the 1950s the mentally ill are now looked upon in a less negative way and a broader range of behaviours are identified as mental illness. But this change may not be as widespread as is sometimes argued.

Several issues are raised in this section of the literature review. For example, there is the question of whether the increased identification of behaviours as mental illness means more or less tolerance. Of particular interest is that it would seem that some of the disparities in research findings have arisen from methodological differences - the types of questions asked and the use of the term

'mental illness'. As was seen, in both the pioneering work in this area and in recent studies, the public identified a broader range of behaviours as disorder (something wrong) than they did as 'mental illness'.

The public may also hold broader views of psychiatric disorder than simply that which is denoted by 'mental illness'. For example, the public, even though they do not identify behaviour as mental illness may still think in terms of degrees of disorder, identifying some as 'nervous breakdowns'. A 'nervous breakdown' may be seen to be at one end of a continuum with 'mental illness' at the other. Alternatively people may consider a 'nervous breakdown' to be a different type of disorder. Labelling theorists have argued that although the public think of mental illness in terms of a stereotype, they may also think in terms of 'medical conceptions' of mental illness. It seems possible from the evidence that people differ along these lines in terms of how they think of psychiatric disorder. It is also possible that these are held as two cognitively distinct conceptions. It also seems that those defined as 'mentally ill' are viewed more negatively than those seen as suffering from psychiatric disorder.

It is also unclear as to what part the mental illness stereotype plays in the recognition of mental illness. Some researchers point out that if people do only think of the mentally ill in terms of a negative and extreme stereotype it is not surprising that there is a high threshold for identifying mental illness. Only a small proportion of behaviours, they argue, conform to this stereotype. It may not even necessarily be applied to people who have been

hospitalised. This is reflected in studies using vignettes where it seems that overall only extreme behaviours are identified as mental illness. It also helps explain the research which has found that family members fail to recognise mental illness among its members and deny that they are ill.

A final issue relating to attitudes to mental illness and the mentally ill addressed in this literature was that of the role of the media in the transmission and reinforcement of stereotypes. Early writers in this area argued that the media played an influential part in reinforcing negative attitudes through its portrayal of the mentally ill in a distorted and stereotypical fashion. Subsequently, several influential forces, such as the anti-psychiatry movement, deinstitutionalisation and the substitution of community care, have developed, all of which might be expected to have influenced public views. Such views may be less negative today but recent studies of the media have shown that negative stereotyping to the point of sensationalism, although probably less vivid than in the 1950s, still exists. It does seem that such stereotypes are persistent. The question remains of the extent to which attitudes are affected by presentations in the media and how such presentations help perpetuate stereotypes.

Although the general public's views are not considered here, patients entering hospital for the first time might be expected to reflect public attitudes. Of particular concern here is how stereotyped these views are and whether the subjects see their own conditions in terms of such stereotypes. In addition, whether or not the media has played part in influencing feelings about hospitalisation

will be considered.

Another issue concerning the labelling perspective and the meaning of becoming a psychiatric patient is that of the subjects' self conceptions. Central to the labelling perspective is the view that a person, once labelled mentally ill, will accept that identity and see him or herself in these terms. Identifying oneself, then, may be viewed either as harmful - from the point of view of the labelling perspective - or as beneficial and indeed necessary, in that insight may be a necessary pre-condition to a successful therapeutic outcome from a psychiatric point of view.

Two concerns, however, arise in this literature: (a) what this identification or denial actually means, and (b) how such identification or denial affects the validity of the labelling perspective. Some evidence indicates that identifying oneself as 'mentally ill' may be associated with longer stays in hospital, thus supporting a labelling perspective. But other research indicates that the issue is more complicated and depends on the type of disorder involved. Still other research argues that identification with or denial of 'mental illness' may have different meanings. Such research finds that while patients considered themselves to be ill, they did not think of themselves as 'mental patients'. Other studies show that patients preserve a positive view of themselves. As with the studies of public attitudes, the use of the term 'mental illness' is considered to be problematic. It seems that this may have different meanings to different people. It may be associated with an extreme and negative stereotype, in which case as has been pointed out, it is not surprising that people reject it, or it may be associated with other types of disorder. Patients may

in fact be only rejecting a mental illness stereotype and not that they have a psychiatric disorder. This issue has also been questioned in relation to the validity of the labelling perspective. A passive view of the labellee has been criticised. It has been argued that the perspective could be broadened to allow for different ways of responding to negative labels.

Another issue which has been considered in the literature as support for or refutation of the labelling perspective is that of patient attitudes towards hospitalisation. Over the past few decades, frequently in response to a recognition of the harmful effects of hospitalisation, numerous policies regarding the commitment and treatment of patients have been implemented. The negative aspects of hospitalisation have generally been stressed by supporters of the labelling perspective. However, it has also been pointed out that there are a number of studies which have not on the whole been central to such discussions but which indicate that patients are not as negative in their views of the psychiatric hospital as is sometimes argued.

It also seems that satisfaction may be associated with a willingness or not to adopt an understanding of the psychiatric patient role. An ideal-type medical sick role appears to a great extent to be incompatible with the psychiatric sick role. Yet some research shows that psychiatric patients often see their role in terms of the former or expect the treatment situation to be similar to that in a medical ward. However, conflicts appear to present a problem for some patients and not for others.

But it must be remembered that this takes place within a context of

considerable change in the psychiatric hospital. Not least important is that a stay in hospital is now relatively short. This is likely to affect patients' views both in terms of attitudes toward the hospital and in terms of their self conceptions as patient.

These issues are of concern here. In particular we are interested in the extent to which the subjects in this research defined themselves as mentally ill, their feelings of satisfaction with the hospital environment and whether this was associated with adaptation to the psychiatric ward. In addition, the relationship between these factors and their perceptions of the admission process and attitudes to mental illness will be considered.

Of concern to labelling theorists, among others, is the idea that people are stigmatised as a result of having been a patient in a psychiatric hospital and that being a patient is one stage in a deviant career.

Two problems appear to arise from the literature on stigma. First is that just as people may choose to accept or to reject the label of mental illness they may also choose to deal with a past experience of hospitalisation in different ways. They may, for example, continue to deny that they were ill or adopt a number of strategies to reverse stigmatisation. Again this points to a less passive view of the labellee than is implied by a narrow statement of labelling theory.

The second issue is whether or not stigma is a problem. If in fact attitudes to mental illness and the mentally ill have changed in a positive direction, then it would be expected that the stigmatising effects of having a psychiatric history would be less than in the past. However, a stereotype of mental illness seems still to exist and therefore

it is likely that people who have been in hospital may have some of its negative connotations attributed to them.

Evidence concerning the existence of stigma is conflicting. Critics of the labelling perspective argue that the negative consequences are not as great as labelling implies. Some research appears to support this position. Other research shows that some negative responses likely result from the individual's behaviour rather than from the label or even from behaviour which is a response to thinking that people know about the label. Yet other research indicates that there is still considerable stigma associated with having been a patient in a psychiatric hospital and that individuals are discriminated against because of this.

As the subjects in the present study had only just arrived in hospital we are not so much concerned here with the actual stigmatising effect of hospitalisation as with the anticipation of this and proposed ways of dealing with it. We are also interested in whether anxiety about stigma relates to other factors, such as feelings of being coerced into a psychiatric admission, stereotypical attitudes towards mental illness or other negative attitudes or dissatisfactions.

If labelling theory is applicable to the experience of becoming a psychiatric patient then we would expect: the subjects to have felt coerced into their psychiatric admission; to consider themselves and their illnesses in a negative way; to express dissatisfaction with being in hospital and to be resistant to treatment; and to anticipate being discriminated against because of their psychiatric hospitalisation. On the other hand, if a psychiatric/sick role perspective is more valid in relation to these subjects' experiences we would expect them: to have

recognised that they had problems and sought help for these; not to consider themselves or their illnesses in a negative way; to adapt to being in hospital and accept the treatment offered; and not to anticipate being stigmatised.

CHAPTER 3

The Method

Initial Aims and Objectives

The aim of this research was to investigate the views of patients when admitted to a psychiatric facility for the first time. The primary objective was to consider patients' perceptions of the admission process, their expectations of the hospital and their attitudes to mental illness - in essence the experience of becoming a psychiatric patient.

It seemed that it might be an advantage not to restrict the sample to patients in one institution but to enlarge it to include subjects from more than one geographical area who were patients entering more than one psychiatric facility. It was decided to extend the study to Canada. This decision was based on several considerations. Much of the literature in this general area is North American (although the distinction between Canada and the US must be kept in mind). My own research experience was in psychiatric hospitals in Canada as well as in Edinburgh and this was an opportunity to further and build on some of the interviews I had developed. Newfoundland was chosen. The opportunity was available to conduct research there and access was likely. The Institute of Social and Economic Research at Memorial University, St John's was supportive in arranging access to the psychiatric facilities and the facilities themselves were interested in having research conducted there.

It was initially proposed that the study be based on a cross-cultural comparison between Edinburgh and St John's, Newfoundland. It was thought that such a comparison would be of value for several reasons. The Royal Edinburgh Hospital takes admissions from a

predominately urban setting, and it would appear to be central to the population from which it draws its patients. Waterford Hospital, as the Provincial psychiatric hospital, accepts patients from rural, indeed some relatively isolated areas, as well as from urban settings. In a highly urbanised and heterogeneous setting, such as Edinburgh, with easy access to treatment facilities and information, different attitudes to mental illness might have been expected from those in a situation such as Newfoundland where admission to a psychiatric hospital might mean isolation and exclusion from the community. Dinham (1977), for example, found that isolated communities in Newfoundland appeared to deal with deviants in the community, but to utilise exclusionary facilities, that is the Provincial psychiatric hospital, in extreme cases for those considered as mentally ill. In addition, various socio-historical factors have meant that many Newfoundland communities have remained relatively isolated from the wider society. It has also been argued by Dinham (1977) that the mass media has had little impact on some societal values because of the lack of information from the media until recently.

For these reasons it was initially proposed to draw a similar sample of first admission patients from hospitals in the two locations.

Changes in Design and Method

While this was initially designed to be a cross-cultural comparison between Edinburgh and Newfoundland, some factors emerged which made it seem more profitable to analyse the data together. Firstly, it seemed that when I considered the data there were in fact more similarities than differences in terms of the types of responses given by the subjects in

the two locations. The numbers subscribing to the different views sometimes varied - and those are discussed in the relevant chapters. However, the meaning of the content of the subjects' statements was essentially very similar once differences in dialect were taken into consideration. There were few differences that were obviously related to the different cultures.

Secondly, had there been obvious differences there still did not appear to be enough relevant information on the cultural backgrounds against which to systematically analyse the data and make relevant comparisons between the two cultures. It appeared, then, that if I analysed the data separately each chapter would conclude with a discussion of a very speculative nature.

Following from these two factors, the focus of the analysis changed from attempting to locate patients' views in the cultural backgrounds to a consideration of the meaning of becoming a psychiatric patient to different individuals with a focus on their personal situations.

The Sample

(a) Access and permission to conduct the research

For permission to conduct the research in the Royal Edinburgh Hospital I submitted a research proposal to the North and South Lothian Division of Psychiatry Ethics Committee stating the background and aims of the research, the number of subjects to be involved, their age range, (1) the criteria for selection, the need for informed consent, the likely

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(1) The normal age range according to the Ethics Committee's guidelines was 16-65 years and justification for including those above 65 would have been necessary. In accordance with these guidelines, this age restriction was proposed

duration and the nature of the interviews. Copies of this proposal were circulated among members of the Ethics Committee and permission was given.

I contacted the Consultant Psychiatrists in each of the acute admission wards or units in the Royal Edinburgh Hospital to request permission to interview patients being admitted to each unit. The research proposal was also circulated among these consultants, other psychiatric staff, nursing staff and other members of the therapeutic teams. I also met with the therapeutic team in each unit to discuss the proposed research. The main concern arising was whether some patients might not find such a lengthy interview tiring. It was agreed that the interview could be terminated at any given time by the patient and that it might also be conducted in two sessions. I also contacted the personnel in the Admissions Office who agreed to inform me of admissions to the hospital as they occurred. Without exception the staff did everything possible at this and later stages to facilitate the research.

Access was similarly obtained in Newfoundland. I submitted the research proposal initially to the Department of Sociology, Memorial University, St John's and then to the Human Investigations Committee of the Faculty of Medicine at the University. After their consideration it was directed for approval to the administration at Waterford Hospital. The Human Investigations Committee granted approval for the research with the following conditions:

(1) no severely disturbed patients will be interviewed;

(2) screening of patients to be interviewed will be done by the nursing and medical staff of the hospital;

(3) where considered appropriate, a nurse may be in attendance at the interview; (2)

(4) interviewing will last from half an hour to an hour or more, but will be terminated at any time on request from the patient or nursing/medical staff.

Waterford Hospital gave approval for this with the additional proviso that a Consent Form should be used.

As in Edinburgh, I submitted research proposals to the psychiatrists involved in each of the acute admission wards and to the Nursing Director and Supervisors. Agreement was also reached with the Medical Records Department regarding obtaining information on patients being admitted to the hospital.

Finally, I adopted a similar procedure to obtain permission to interview patients at the General Hospital Health Sciences Centre through their Medical Advisory Committee. The nursing staff and the ward clerk agreed to inform me about admissions to the psychiatric unit.

(b) Selection criteria

It had been decided to draw the sample only from the acute admission units described above, except where a patient would ordinarily have been admitted to such a ward but because of bed shortages had been directed elsewhere. First admission patients were admitted to other wards in both the Royal Edinburgh Hospital and Waterford Hospital but these were excluded for various reasons. In Edinburgh this included

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(2) In fact this did not happen. No third persons were present at any interviews either in Edinburgh or St John's

patients admitted to the 'Unit for the Treatment of Alcoholism', the 'Young People's Unit' and the 'MRC Brain Metabolism Unit' because of the specialised nature of these wards. Patients were also admitted to both the Royal Edinburgh Hospital and Waterford Hospital, more so in the latter, through the judicial system. This included people awaiting trial or found to be mentally ill in the course of a trial and, in Waterford in particular, those sent from the courts for psychiatric assessment. In most instances such patients were admitted to wards other than the acute admission units. It was also decided to exclude any of those from the sample should they happen to be admitted to one of the acute units. It was considered that their views on their admission procedure, their expectations of treatment, their perceptions of their own problems and their views on stigma would all be conditioned by their own particular situation and would not be representative of first admission psychiatric patients in general.

Of those admitted to the acute admission units, anyone with known organic cerebral damage, and anyone under 16 or over 65 was also automatically excluded. Although in fact many people over the age of 65 are admitted to hospital for the first time with acute psychiatric disorders, people above this age are considered as a distinct group and the hospitals' Ethics Committees preferred this as a cut-off point. In addition it was necessary to exclude patients admitted to Waterford Hospital with mental handicap. This information was generally available either from the various admissions and records staff or from the ward staff.

It was also decided to include only patients who originated from or were ordinarily resident in or around the catchment area of the hospital.

This was to control cultural factors as much as possible. In fact, in both Edinburgh and Newfoundland, very few patients were excluded for this reason.

In both locations a 'first admission' to the psychiatric facility from where the sample was being drawn was not necessarily a 'first admission' per se. Determining this in Newfoundland was more complex than in Edinburgh because of the existence of the number of psychiatric facilities dealing with the same catchment area. A much larger number of patients admitted to the facilities in Newfoundland, compared to those in Edinburgh, deemed to be 'first admissions' had in fact previously been patients in other psychiatric units. This was particularly a problem in Waterford Hospital. It was desirable to be more stringent there than in Edinburgh in determining previous psychiatric history prior to making personal contact with the patient. This information was usually available from the ward staff. As in Edinburgh, this was also checked with the patients themselves when an interview was requested. Occasionally patients disclosed the fact that they had been in hospital previously when it had been widely believed that they had not.

Potential subjects, then, were essentially first admission patients, within a specific age range, suffering from acute psychiatric disorder, ordinarily resident in the catchment area of the hospital and had been admitted to a psychiatric facility for the first time to one of the units selected for the study.

(c) Patients fulfilling the selection criteria but not included in the sample

Not all of the patients who fulfilled the criteria for selection were eventually included in the sample. Some were not approached for an

interview at all. These either had medical or physical problems which prevented their participation or they were considered to be too disturbed during the first five days of their stay in hospital. In addition some patients discharged themselves or were discharged before an interview was possible. A number refused to be interviewed and some interviews were never completed. Those patients not included in the sample are documented in Table 3:1.

TABLE 3:1 Patients Fulfilling the Selection Criteria but not included in the Sample

	Royal Edinburgh Hospital	Waterford Hospital	Health Sciences
Too disturbed	3	12	4
Too physically ill/not physically capable	1	4	1
Refusals	7	3	1
Discharged before interview	8	5	5
Incomplete interview	3	3	-

Deafness, blindness and some deafness, stroke, anorexia nervosa and general debility were the reasons why six patients were not interviewed because of their physical condition.

More patients in Waterford Hospital were not interviewed because they were considered too disturbed or disoriented than in either of the other two facilities. This probably reflects the tendency of family doctors and psychiatrists in Newfoundland to direct more disturbed patients to the Provincial psychiatric hospital than to psychiatric units in local general hospitals.

Patients were generally approached regarding an interview within three days of their admission. That a number discharged themselves or

were discharged before an interview could be requested is of some interest. Some of these only stayed in hospital overnight.

There were a few patients in both Edinburgh and Newfoundland who had initially been considered too disturbed or disoriented to be interviewed but who discharged themselves soon after their admission. (3) In addition a few of the 'incomplete' interviews resulted because a discharge procedure was finalised. For example, I started to interview a male patient one evening but postponed completing this because his visitors arrived. The patient agreed to continue with the interview the next morning and gave no indication that he was planning to leave the hospital. He was discharged that morning before I arrived.

In fact little is known about those who stayed in hospital for such a short time. Some, particularly those who had been considered too disturbed or disoriented to be interviewed, likely discharged themselves against the wishes of the psychiatrist. That this was possible is an indication that people admitted to psychiatric hospitals are not necessarily forced into staying against their will, although it is likely that attempts were made in these instances to persuade the patients that remaining in hospital would be for their benefit. Other patients who stayed in hospital for only one or two days appear to have discharged themselves or been discharged because the problem or crisis which had precipitated their admission no longer troubled them to the extent that being in a psychiatric hospital was seen as the most appropriate option.

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(3) These are included in Table 3:1 under 'Discharged before interview'

The patients who refused to be interviewed were not asked why as this might have been interpreted as coercion. Some, however, volunteered that they were reluctant because of a general anxiety about being stigmatised. One, for example, a nurse in another hospital, said she wanted as few people as possible to be aware of the details of her admission because of a concern that her status as an ex-psychiatric patient might adversely affect her job. Another patient admitted during the period of interviewing was a GP and his psychiatrist and the nursing staff advised against requesting an interview as they too, concerned about stigma, were attempting to conceal details of this admission from as many people as possible. This was the only instance where access to a patient capable of an interview was denied.

Other than this one case there was no evidence that staff members in either location screened out the patients I was permitted to approach. In fact two of the 'incomplete' interviews were where I did not think the patient could fully comprehend the questions asked when the staff had thought they would be capable of such an interview. In general it appeared that the staff's definition of someone who could be interviewed approximated my own.

From Table 3:1 it can be seen that of the 60 patients fulfilling the selection criteria but not included in the sample, 43 were not approached for an interview. This represents 39% of all patients meeting the criteria. The views expressed by the subjects in this research then may not be totally representative of all first admission patients with acute psychiatric disorder in the facilities in the study. Some of those not included in the sample because they discharged themselves possibly would have held less favourable attitudes towards

hospitalisation than the majority of those who were eventually interviewed. Their views may have been similar to those of a small group of subjects who, when interviewed, said they did not want to be in hospital and wished to discharge themselves. It also appears that those who refused were generally anxious about the stigma associated with hospitalisation. Nothing is known about the other missing cases. This must be taken into account when considering the representativeness of the views obtained from the subjects in the sample.

(d) Subjects included in the sample

The 50 subjects in Edinburgh were selected in sequence as they were admitted to the Royal Edinburgh Hospital from July to September 1979.

Interviewing started in Waterford Hospital in October 1979 and in the Health Sciences Centre in April 1980 and finished in October 1980 when 50 interviews had been completed. Twenty-six Waterford Hospital and 24 Health Sciences Centre patients were interviewed.

The 100 subjects in the sample were distributed among the admission units or wards as follows:

TABLE 3:2 Subjects Admitted, by Hospital

Ward/Unit	Males		Females	
Edinburgh				
Royal Edinburgh Hospital				
Professorial Unit 1	2		5	
Professorial Unit 2	6		2	
3 and 4	5		2	
6	2		2	
North Wing	2		4	
22 and 24	6		4	
Queen's Craig 1 and 2	8		0	
Edinburgh total		31		19
Newfoundland				
Waterford Hospital				
North 3A	8		3	
North 4A	7		4	
North 2B (security)	2		0	
North 3B (security)	2		0	
	19		7	
General Hospital Health Sciences Centre				
Psychiatric Unit	11		13	
Newfoundland total		30		20
Sample total		61		39

As was mentioned above, the subjects in Waterford Hospital were selected as they were admitted to one of two acute admission wards in the hospital. However, bed shortages during the period of research, particularly during the Christmas holiday period, resulted in four subjects, who would ordinarily have been admitted to one of these wards, being directed to one of the two 'security' wards which usually housed patients admitted through the judicial system.

Interview Schedule Design

This research used in-depth semi-structured interviews based around an interview schedule designed to address the variety of topics relating to the subjects' experiences, attitudes and expectations. Such a method seemed likely in this situation to prove most advantageous in obtaining a broad variety of responses and to permit a wide exploration of the subjects' opinions and perceptions. (4)

The use of a more structured questionnaire was rejected because it was not considered that this could fully elicit the patients' subjective interpretations of the meaning of hospitalisation. In addition, the sensitive nature of some of the questions to be investigated required that the subjects be given the opportunity to explore in detail areas of particular concern to them.

On the other hand, the possibility of using a totally unstructured interview was also rejected because it was considered that the subjects might concentrate only on their immediate problems. In addition, it

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(4) The desirability of flexibility in order to obtain such detail is discussed by, among others, Lofland (1971)

was thought advisable to avoid any indication that the interview was part of a therapeutic process.

The interview focussed on various dimensions of particular interest and the schedule was designed to address the following broad questions:

(a) How did these first admission patients perceive the process leading to their psychiatric admission? Who did they consider to be involved in this?

(b) What were their expectations of the hospital and of psychiatric treatment and how did this compare to their experiences?

(c) What did they think was the purpose of the hospital? How did they define the roles of psychiatrists, nurses and other members of the therapeutic teams? What did they expect or hope to obtain from psychiatric treatment?

(d) What information did they possess about the nature of psychiatric disorders and psychiatric treatment? What did they consider to be the role of psychiatry and other help sources in relation to various problems?

(e) What was the nature of their past experience in this area, direct or indirect, with other people or through the media?

(f) How did they perceive their own problems and those of other patients? How did they define mental illness and what did they think caused it?

(g) Did they plan to disclose the fact of their hospitalisation after being discharged? What did they expect to happen as a result of this?

As was seen in Chapter 2, the general areas to be considered in this research were influenced to some extent by points of interest arising from the literature. In addition, however, some specific questions previously used were adapted for the purposes of this research.

For example, Maclean (1967) focussed on the distinction between

'mental illness', 'nervous breakdown' and 'insanity' and beliefs regarding the causes, course and prospects of cure for mental illness. Some of Townsend's (1978) questions addressed similar points. Weinstein and Brill (1971) also investigated beliefs regarding the causes of mental illness. Questions based on these areas were asked directly in this research.

Also included in this interview schedule were questions similar to Townsend's (1978) 'How can you recognise a mentally ill person?' 'Do you consider yourself mentally ill?' and 'Are other patients mentally ill?'

Elinson et al (1967) investigated the question of 'What to do and where to go for longstanding problems', 'Why people with troubles don't go for help' and 'Whether a state mental hospital is most like a general hospital, a TB sanitorium, a prison, a boarding house or a nursing home'. Questions similar to these were also included here.

More generally, questions on expectations of the hospital were influenced by Ferguson (1974), on stereotypes and the media by Nunnally (1961) and Townsend (1978), and personal perceptions of illness by Denzin and Spitzer (1966).

It was thought that directly addressing particularly sensitive areas such as whether the subjects thought they were mentally ill might be too distressing and might result in defensiveness. This was avoided with the use of a variety of questions relating to perceptions of illness. The final questions regarding post-hospital expectations were also thought to be potentially distressing and were worded indirectly to elicit their fears regarding stigma.

Fifty-five interviews were conducted in Edinburgh. The responses

from the first five, though not strictly speaking a pilot study, were used to consider the appropriateness of the interview, the timing and the actual questions asked. A few small changes were made in the wording of some of the questions at this stage. The final interview schedule is in Appendix I.

In addition to these changes, the interview schedule was altered to accommodate differences in dialect as well as situational differences prior to commencing the interviewing in Newfoundland. These alterations were made after consultation with a sociologist, an anthropologist, a psychiatrist and a specialist in education - all familiar with Newfoundland culture. These changes are listed in Appendix II.

The Conduct of Interviews

The subjects were selected in sequence until a traget of 50 in each location was reached. This took place over a two month period in Edinburgh and the subsequent year in Newfoundland.

In general, unless I was on the ward at the time of an admission or if the admission had been pre-arranged, it took at least one day to check that a patient had been admitted to the ward, that this was the first time they had been admitted and whether he or she was in a condition to be interviewed.

In Edinburgh, I contacted the Records Office each morning for details of the previous day's admissions. Generally the staff there knew whether or not an admission was a first or not from the records or lack of them and from the 'Admission Slip' sent from the wards. The ward or unit was then contacted to confirm this and to consider whether

the patient was in a suitable condition to be approached regarding an interview. At weekends I contacted each of the ten wards either by telephone or in person to see if they had admitted any new patients.

I adopted a similar procedure in St John's. In Waterford Hospital, I contacted the Admissions Office each morning and then the wards. At weekends I approached the Nursing Supervisor on duty who dealt directly with all admissions from Friday night to Sunday. In the Health Sciences Psychiatric Unit, the clerk in charge of admissions and records confirmed the previous day's admissions.

Anyone considered by the medical and nursing staff to be too disturbed to be interviewed was not approached directly. Anyone who was still considered too disturbed by the fifth day after their admission was excluded from the sample.

It had also been agreed that patients who might be considered by the psychiatrist or nursing staff as possibly being adversely affected by the length of interview would not be included. In general this turned out to be patients who were too physically ill or not physically capable of an interview.

In the Royal Edinburgh Hospital and in the Health Sciences Psychiatric Unit in St John's, agreement only with the ward staff was necessary, according to the conditions of the various hospital committees, prior to contacting a patient. In Waterford Hospital, however, I was asked to confirm with each patient's psychiatrist before requesting an interview. In addition, each patient to be interviewed was asked to sign a consent form.

The staff also reserved the option of asking that an interview take place over two or three sessions given the length of time required. It

was thought that some patients might find it too tiring. In practice where a break was taken in an interview, this was initiated by myself and the subject and not by staff members.

Arranging an exact time for an interview was not usually possible because of ward programmes, other scheduled activities, the patient's treatment and visitors. However, it was often possible to ascertain when a patient was likely to be free. This became easier as I became acquainted with different wards and routines - both formal and informal. Arranging interviews at the weekend and in the evenings was more straightforward than during weekdays because of fewer organised ward activities, although then, as during the day, the patients' own situations had to be considered first. Visitors arriving before or even during an interview had priority as did any unscheduled visits from a psychiatrist.

In most instances the patient was introduced to me by a member of the ward staff. I explained the purpose and the nature of the interview to each patient approached, stressing that it was their opinion I was interested in and that it might take an hour or two of their time. The confidentiality of the interview was stressed. They were told that what was said would contribute to a thesis but that names or other identifying details would not be used. I also asked if I could tape-record the interview, again stressing that this would be confidential and that members of the hospital staff would not hear the recording. I also emphasised to each prospective subject that participation in an interview was entirely optional, that it was not related to their treatment and that declining to be interviewed would not affect them in any way. They were also told that they could terminate the interview any time they

wished. There was a total of eleven refusals at this stage.

Because of the interest in first admission patients' expectations of hospitalisation and perceptions of the process leading to their admission, it was considered desirable to conduct the interviews with the subjects as soon after their admission as possible. On the other hand, the interest in their perceptions of the hospital and their understanding of their own treatment and their patient role necessitated some familiarity with the surroundings. It became apparent, however, in conducting the first five 'trial' interviews, that the optimum stage to interview a subject would largely depend on individual circumstances. (5) In addition, the timing would depend on contingencies such as ward routine. Each interview lasted from one to three hours depending on how much each subject wished to say about a topic. Most of the questions in the interview schedule were designed, with the use of probes, to elicit detailed responses. Some subjects expanded in considerable detail giving views, anecdotes and examples. Others were less opinionated on some matters.

The questions were not necessarily asked in order. Indeed they were not all asked directly. Subjects frequently gave their opinions on one area while responding to another point. The appropriateness of a question largely depended on the previous response. In addition there was some overlap and redundancy.

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(5) 85% of the 100 subjects in the sample were interviewed within four days of their admission and the remaining 15% within five days. The median length of stay in hospital prior to the interview was 2.5 days

Once an interview had been agreed to there were few problems. There was very little reluctance regarding the use of the tape recorder and most subjects seemed to forget about its presence once the interview commenced. One subject included in the sample refused to be recorded on tape, but was quite willing to talk and allow me to take extensive notes.

Despite some anxieties expressed at the outset of the research, these subjects did not on the whole appear to be unwilling to impart information. There had also been some concern that some of the questions might be thought too personal or threatening in some way. However, many said that they found relief at being given the opportunity to express their views. A few subjects became tearful or upset during the interviews, which was not surprising given that they were discussing what was essentially a distressing experience. When this happened, we usually stopped for coffee and resumed the interview when suggested by the subject. It had been explained prior to the interview that such a break could be taken if they wished.

Some other interviews were interrupted because of the arrival of visitors or of the patient's psychiatrist or because the interview extended into a time allocated for ward activities.

A very few interviews were never completed. This was either because I considered that the patient could not understand the questions being asked and/or they demonstrated extreme reluctance to continue or because they were discharged from hospital.

Method of Analysis

The subjects' responses from the tape-recorded interviews were transcribed verbatim. Once this was completed, the transcripts were reviewed to consider the main areas of interest emerging from the data.

The questions asked in the interviews had been based on several topics of theoretical interest and some of these remained the focus of the analysis. However, some questions and indeed some of the areas which were originally of interest did not elicit adequate data to be included in detail. These were: knowledge of psychiatric disorders and psychiatric treatment; opinions about sources of help for problems and the general role of psychiatry outside the institutional setting; why people do or do not seek professional help; knowledge of other patients; the role of hospital social workers and clinical psychologists; and the meaning of a variety of terms describing behaviour or conditions.

The main areas of interest emerging and focussed on were: perceptions of the processes leading to the hospital admission; expectations and perceptions of the hospitals or units and the patient role in relation to this; beliefs regarding the causes of mental illness; attitudes towards the nature of mental illness and self-perceptions of illness; and plans to disclose details of hospitalisation after discharge. The greatest variety of responses obtained, then, related to the subject's own personal experiences and situations and the least variety and least information generally related to topics outside this.

The five topics provide the basis for Chapters 5 - 9. On each topic the dominant themes emerging from the subjects' responses were drawn out and the characteristics of these themes developed as categories. The numbers of subjects subscribing to each of these themes or categories

were noted. These categories, with illustrative examples, are presented within the context of the major issues of interest. The relationships between the numbers subscribing to each category on each topic are considered in the analysis. Other variables are also considered in relation to these categories, namely: sexual status, age, marital status, educational level, occupational status, employment status (whether employed or not), psychiatric diagnosis, and experience of psychiatric treatment (out-patient treatment or association with others who have had psychiatric treatment) in the past.

CHAPTER 4

The Psychiatric Settings and Characteristics of the Subjects

The Psychiatric Settings

(a) Edinburgh

The Royal Edinburgh Hospital is a NHS teaching hospital with long-standing and close ties with the University of Edinburgh. These date from 1853 with the first official teaching appointment at the hospital and the first course of clinical lectures, although lectures had been conducted at the hospital since 1823. (1) The first Chair of Psychiatry at the University was in 1918 and the then Physician Superintendent of the hospital became the Professor. These two positions were separated in 1955. Today, in addition to providing a wide range of services dealing with the full spectrum of psychiatric disorders, the Royal Edinburgh Hospital continues this teaching and research tradition. It primarily serves the greater Edinburgh area and also at times the rest of Scotland.

The Royal Edinburgh Hospital has gone through a number of changes and developments since its early conception. Plans for an 'asylum' in Edinburgh were instigated in 1792 by the Lord Provost and other city officials, the Royal College of Physicians and a body of trustees. Much of the impetus for this came from the influence of Andrew Duncan, then President of the Royal College of Physicians in Edinburgh. In 1809 a Royal Charter for a public asylum was granted and in 1813 the

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(1) This and other historical details are summarised from Henderson (1964), the Royal Edinburgh Hospital (1965 and 1970) and personal communications from Dr J W Affleck, former Physician Superintendent of the Royal Edinburgh Hospital and from L de Jean, Medical Archives Centre, University of Edinburgh

Lunatic Asylum of Edinburgh was opened. Its early development owed much to contemporary humanitarian beliefs and practices concerning the treatment and care of the mentally ill - most notably those of Pinel and Tuke - but even against this its early functioning, in line with universal practice, was custodial.

The hospital was expanded in 1843 with the opening of West House, now MacKinnon House (after the first Physician Superintendent, Dr William MacKinnon), and became known as the Royal Edinburgh Asylum for the Insane/Royal Edinburgh Asylum. Further extensions were made with the opening of Craig House in 1894, located in grounds not far from West House. The Royal Edinburgh Hospital today is centred in these two sites.

Changing attitudes regarding the treatment and care of the mentally ill resulted in pressure to change the hospital's title and remove the word 'Asylum'. It was renamed the Royal Edinburgh Hospital for Mental and Nervous Disorders in 1922. The Managers Minutes of 26 November 1908 read:

> The meeting specially approved the use of the word 'Asylum' be discontinued in all letters concerning patients written from Craig House or West House and that the word be no longer stamped on the crockery or articles of any other kind in the institution.

In the hospital records from 1922-1927 it was referred to as the Royal Edinburgh Hospital. (This finally became its title in 1955.)

With the opening of the Jordanburn Nerve Hospital in 1928, next to MacKinnon House, patients were admitted on an informal basis outwith the Lunacy Acts. (2) The Andrew Duncan Clinic (named after the

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(2) Voluntary admission was legal in Scotland from 1862. However a patient admitted on an 'informal' basis has the same status as any other hospital patient

hospital's founder), including the Professorial Units, was opened in 1965 for short and medium stay patients. There were also facilities for a large out-patient department.

In 1972 Craig House was renamed the Thomas Clouston Clinic (after the Physician Superintendent influential in its construction) - the inclusion of the term 'clinic' denoting contemporary treatment ideologies and stressing its similarity to the Andrew Duncan Clinic.

At the time of this research the acute admission units were located in both of the two main hospital sites. There were four such wards with a total of 74 beds in the Thomas Clouston Clinic. Two wards (22 and 24) were in the main building of Craig House and two in the adjacent building, Queen's Craig. In the other location there were three acute admission units in the Andrew Duncan Clinic (3, 4 and 6), plus the two Professorial Units; these housed a total of 118 patients. The North Wing - a 16 bedded unit - was adjacent to the main building of MacKinnon House.

These units were all unlocked, with the exception of the two in Craig House, which were kept locked depending on the ward population. This was considered to be for the safety of older patients who might have problems negotiating the steep stairs and not for purposes of confinement.

The Edinburgh half of the sample was drawn from these ten acute admission units. These wards admitted patients from a variety of referral sources, including the out-patient department at the Royal Edinburgh Hospital itself, the Royal Infirmary of Edinburgh, other general hospitals or Health Centres in the city, and GPs. Occasionally patients referred themselves directly to the hospital.

In addition to these usual referral sources, Professorial Units 1 and 2 were specialised wards taking referrals from other units or hospitals. There was a special interest in P U 1 in the treatment of anorexia nervosa. P U 2 took admissions from the University Student Health Centre and the North Wing admitted patients directly from the Regional Poisoning Treatment Centre at the Royal Infirmary of Edinburgh.

For purposes of referral and admission, Edinburgh was divided into four sectors. Patients were generally admitted to the particular units on that basis, although bed shortage sometimes resulted in patients being sent to other wards. In addition, all of these wards accepted in rotation patients of 'No Fixed Abode'. Generally wards 3 and 4 admitted from North-East Edinburgh; ward 6 from North-West; wards 22 and 24 from South-East and Queen's Craig 1 and 2 from South-West.

Each of these wards was more or less run on the basis of a therapeutic community, although the extent to which this was adhered to varied depending on the Consultant Psychiatrists and the nature of the ward population. P U 1, at one extreme, had a tightly scheduled programme of patient activities and stressed the democratic participation of all members in these activities. There was, in addition, an emphasis on analytical group therapy. At the other extreme, wards 22 and 24, located in the older part of the hospital in Craig House, housed a few older patients who had been resident for some time and a similarly scheduled programme oriented to all members was not as feasible.

Treatment on these wards or units was generally described by the

Consultant Psychiatrists as 'eclectic' and included, depending on the individual patient, drug therapy, group therapy, E C T, occupational therapy and behaviour therapy.

In 1979, when this part of the research was conducted, there were 2,364 (3) admissions to the Royal Edinburgh Hospital, of which 954 were first admissions. The average length of stay was relatively short at six weeks for male patients and ten weeks for female patients. This reflects a combination of policies actively encouraging discharge into the community, the control of many illnesses with psychotropic drugs and the transient nature of many disorders. (The average stay for females may possibly be partly accounted for by the predominance of females over 65 admitted to the hospital. It is also possible that the predominance of male patients with alcohol related problems lowers the average stay of males compared to females. The statistics on all discharges from all mental hospitals in Scotland in 1979 show that 79% of males with alcoholism or alcoholic psychosis were discharged in under four weeks. This compares with 60% of males and 54% of females suffering from psychoneurotic disorders.)

The average duration of stay in the acute admission units was considered by the Consultant Psychiatrists to be much shorter at around three to four weeks. This also reflects the short term nature of acute psychiatric disorders.

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(3) This and other statistical details are taken from information made available by the Royal Edinburgh Hospital and from the Scottish Health Service, Common Services Agency, Information Division (1979/80)

(b) Newfoundland

Waterford Hospital is the Newfoundland Provincial psychiatric hospital. It is a teaching hospital serving the entire Province, offering facilities for the treatment and care of the full range of psychiatric disorders. Its tradition as a teaching facility is more recent than the Royal Edinburgh Hospital, having established its training programmes in the 1940s. (4) At first it was affiliated with Dalhousie University and then with Memorial University of Newfoundland Medical School.

The General Hospital Health Sciences Centre Psychiatric Unit is one of 13 facilities in Newfoundland offering psychiatric treatment and care in units attached to general hospitals. Located in St John's, the General Hospital Health Sciences Centre is also a teaching hospital attached to the University.

The early development of what was to become Waterford Hospital owed much to humanitarian attitudes towards the mentally ill in the nineteenth century and the British and European experience. Henry Hunt Stabb, who had been educated in Edinburgh, was largely responsible for establishing Palle's Farm as a 'moral treatment asylum' on the outskirts of St John's in 1846. This became known as the Provincial Lunatic Asylum and Dr Stabb was appointed Superintendent.

In 1852 the House of Assembly allotted money for land for a permanent hospital and the foundation stone was laid in 1853. Waterford Hospital itself was opened in 1855 under the title of the Asylum for the Pauper Lunatics. All patients at this time were

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(4) This and other historical details are summarised from Williams et al (1972), Waterford Hospital (1980) and Pottle (1980)

admitted only by medical/legal committal and early care was largely custodial. The patients themselves played some part in the construction of an extension to the hospital which may have been considered therapeutic. This and another extension were opened in 1875 and 1877.

Until 1940 the hospital was variously known as the Lunatic Asylum, the Insane Asylum and the Mental Hospital. In 1940 it was renamed the Hospital for Mental and Nervous Diseases.

Until 1945 this hospital had the only programme of psychiatric treatment in Newfoundland. 1946 brought a complete reconstruction of the system of psychiatric care in the Province and a programme of decentralisation was begun. Consulting and treatment privileges were given to medical staff in general hospitals and out-patient services became available in Waterford Hospital, the General Hospital (now the General Hospital Health Sciences Centre), St Clare's Mercy Hospital and the Grace General Hospital - all located in the Provincial capital of St John's. Programmes of day care treatment were also started at this time.

It is only in recent times that psychiatric facilities have been available outside the capital. The 1960s and early 1970s saw the initiation of facilities in general hospitals in other towns in Newfoundland. At the time of this research there were eight psychiatric facilities attached to general hospitals outside St John's and five in St John's itself, one of which specialised in the treatment of children. Of the facilities in St John's, two are focussed on in this research - Waterford Hospital, which remains the Provincial Hospital, and the General Hospital Health Sciences Centre

now located on the campus of Memorial University.

When this research was conducted there were two acute admission units with 55 beds in Waterford Hospital. In addition, in instances of bed shortage, acute admission patients were occasionally admitted to one of two other wards in the same building which normally admitted patients considered to require security precautions - mainly those admitted through the judicial system. In fact the two acute admissions units were also normally locked but access to these was not as restricted as to the 'security' wards.

The psychiatric unit in the General Hospital Health Sciences Centre was a spacious self-contained 20 bedded unit attached to the hospital. This was not locked.

Because there were fewer acute admission beds in the two facilities in St John's than in the Royal Edinburgh Hospital, it took considerably longer to obtain the Newfoundland half of the sample (one year as compared to two months in Edinburgh). Under ideal circumstances, first admission patients might have been selected from all the psychiatric units in St John's and even from facilities in other towns in Newfoundland, but the organisation and resources required for this were beyond the scope of this research.

Patients were admitted to these units after being referred from a variety of sources. These were mainly family doctors, other general hospitals or psychiatric units and psychiatrists in private practice. As in Edinburgh, these wards occasionally admitted patients who had referred themselves or who had been brought by family members.

As Waterford Hospital was the Provincial hospital, patients were referred there from throughout Newfoundland. In some instances,

patients whom it was felt could not be managed in unlocked 'open' psychiatric units were referred there. Patients from outside St John's and vicinity were also referred to the Health Sciences Centre but not as frequently as to Waterford Hospital, the local general hospital psychiatric units sometimes providing alternatives. Whether a person was referred locally or to St John's appeared to depend on a variety of contingencies. These included previous psychiatric history, the considered need for specialist medical treatment or investigation, the preferences of the referring family doctor or psychiatrist, the perceived need for constraint, staff availability, availability and accessibility of in-patient psychiatric facilities and whether space was available at a given time. At the time of the research only six of the eight psychiatric units outside St John's had in-patient facilities and the total number of beds in these was only 80. Two of these units had only six beds each.

The treatment in the acute admission wards in Waterford Hospital and in the General Hospital Health Sciences Centre Psychiatric Unit, as in Edinburgh, was generally considered to be eclectic and included a similar variety of therapies. There was, however, less emphasis on group and occupational therapy in the wards in Waterford Hospital than in the Health Sciences unit. The latter also had a more cohesive and organised structure of treatment activities which also included social skills and assertiveness training. Such a programme was probably less feasible in Waterford Hospital which performed a custodial as well as a therapeutic function.

In 1979 there were 688 (5) admissions to Waterford Hospital,

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(5) This and other details were taken from statistics made available by Waterford Hospital and the General Hospital Health Sciences Centre Psychiatric Unit and from the Newfoundland Department of Health (1980) and Statistics Canada (1980)

176 of which were first admissions. In 1980 the figures were 831 and 187. Admission statistics for the Health Sciences Centre Psychiatric Unit were not available but in 1979, 133 patients were discharged, 22 of whom were first admissions. In 1980 these figures were 262 and 71. This represents a considerable proportion of all psychiatric admissions in Newfoundland. In 1980, 3011 patients were discharged from psychiatric facilities in the Province, 856 of whom were first admissions.

The average duration of stay in Waterford Hospital was 32.5 days in 1979 and 26.9 in 1980. In the Health Sciences Centre Psychiatric Unit from April 1979 to March 1980 this was 27.7 days.

Characteristics of the Subjects

The subjects were asked about their present or last occupation, how long they had been employed at this and what other jobs they had previously held. Details were also obtained about housing, educational level and qualifications. They were not asked about their income or parents' occupations. While this might have been used as an indication of social class, it was considered that comparing the two groups of subjects in the two areas would be problematic on this basis given differences between the two cultures. It seemed more useful to use a measure of occupational status.

The data on occupation was analysed using the Office of Population Censuses and Surveys Classification of Occupations (1980). Both the Edinburgh and Newfoundland data were considered in this way. Occupational information was available for 89 of the 100 subjects. The remainder comprised seven university students and four others (two

males and two females) who had never worked. Because the numbers were small, these subjects were included in the manual/non-manual categories rather than as a separate category. Those who had never worked were classified according to their educational attainment and qualifications - on the assumption that this is an indicator of subsequent type of employment. One of these who had attended university for one year was classified as non-manual, as were the seven university students. Three who had attended school for less than nine years were classified as manual.

Classifying females by occupational status is problematic as it may or may not reflect that of their husbands or their families of origin. Although husbands' occupation was obtained, it was decided, for the sake of consistency, to classify married women (and unmarried women) by their own or previous occupation. It must also be noted that women's occupations tend to be predominantly non-manual. This is reflected in Table 4:1 which gives details of the subjects' occupational status.

There were more manual than non-manual workers in both Edinburgh and Newfoundland and particularly in the latter. This is more noticeable for the male subjects - only 16 of the 61 males in the entire sample were employed in non-manual occupations and only six of these were from Newfoundland. In fact there were only three professionals (all male) in the entire sample. It may be that professionals are more likely than others to resort to other sources of help and to avoid hospitalisation. In Newfoundland in particular alternative counselling services were available or even treatment outwith the Province.

TABLE 4:1 Subjects' Occupational Status - by Location and Sexual Status

Occupational Status	Location and Sexual Status					
	Edinburgh			Newfoundland		
	female	male	total	female	male	total
Non-manual	13	10	23	12	6	18
Manual	6	21	27	8	24	32
Total	19	31	50	20	30	50

Although a non-manual/manual breakdown was obtained for the entire sample of 100 subjects (based on present or previous occupation) almost half were not currently in paid employment. This included housewives, students, long-term unemployed and never employed, recently unemployed and retired persons. (Long-term unemployed is taken here to be over one year.)

The distinction is made here between subjects currently in employment and those not employed because it was thought that such a classification might be a more salient predictor of attitudes than social class measured on the basis of non-manual/manual status. Both of these variables are considered in Chapters 5 - 9 in relation to the subjects' views.

These subjects are represented in Table 4:2. Comparing males and females is problematic given the classification of 'housewife'. The majority of the 14 subjects who were recently unemployed had become so on average two to three weeks prior to the psychiatric admission. It is not possible to ascertain whether unemployment had contributed in some way to the psychiatric admissions or if it had come about because of some aspect of a psychiatric disorder or disturbance, or indeed neither. Of the 22 who were unemployed, 16 were Newfoundland subjects.

This partly reflects a high level of unemployment in that Province in particular and in the Maritime Provinces in Canada generally.

It is apparent that only a small number - eight - had been unemployed on a long-term basis. In addition, there was little evidence of downward mobility. Most subjects were currently employed in similar occupations to those they had occupied during their working lives. Of course these subjects were first admissions and as such had not assumed a chronic patient role which is more likely to fit with this image. In addition, those patients who were excluded from the sample because they were too disturbed to be interviewed may have been in less stable employment situations.

TABLE 4:2 Subjects Not Currently Employed, by Sexual Status

Subjects not Employed	Sexual Status female	male	total
Housewives	17	0	17
Long-term unemployed/ never employed	0	8	8
Recently unemployed	1	13	14
Retired	2	1	3
Students	5	2	7
Total	25	24	49

Details were also obtained about accommodation. Because the relationship of housing tenure to social class is different in the two countries, these details are not considered in the analysis. Being an owner-occupier in Canada, for example, does not necessarily reflect being middle-class. While this data is not used in the analysis, it is of interest to note that the majority apparently lived in stable housing situations and not in temporary accommodation.

TABLE 4:3 Subjects' Accommodation, by Location

Accommodation	Location		
	Edinburgh	Newfoundland	Total
Owner-occupier	16	35	51
Local authority	21	1	22
Housing Association	3	0	3
Privately rented	3	10	13
Tied home	2	1	3
Boarding/student accommodation	4	3	7
No Fixed Abode	1	0	1
Total	50	50	100

Not all of those classified here as living in 'owner-occupied' accommodation were in fact owners themselves. Nor were all those who lived in rented accommodation the main tenants. A number of subjects lived with their parents, or with other adults which in some instances included other family members, such as siblings or adult children. These patterns are seen in Table 4:4.

A large proportion (48% in Edinburgh and 38% in Newfoundland) lived either with their spouse alone or with their spouse and children. The higher percentage (30% as opposed to 16% in Edinburgh) likely partly reflects the younger age of Newfoundland subjects (which can be seen below in Table 4:7). It may also reflect a scarcity of rented accommodation.

'Living Group' is not considered in the analysis because of the large number of categories.

TABLE 4:4 Subjects' Living Group, by Location

Living Group	Location		
	Edinburgh	Newfoundland	Total
Alone	7	7	14
With spouse	6	3	9
With spouse and children	18	16	34
With dependent children	3	3	6
With parents	8	15	23
With other adult	7	6	13
No Fixed Abode	1	0	1
Total	50	50	100

A higher percentage (50%) of Newfoundland than Edinburgh male subjects were single. Most of these were young adults. These also tended to be the same subjects who lived at home with their parents.

The breakdown of marital status in Table 4:5 is of interest in that six (12%) Edinburgh and 11 (22%) Newfoundland subjects were separated from their spouses. By way of comparison, only one percent of all household members in Britain in 1980 (6) were 'separated'. Many of the subjects in this research had been suffering from a variety of problems - including interpersonal problems - for some period of time. This is reflected in the relatively high proportion of those 'separated'.

(6) This is taken from the Office of Population Censuses and Surveys : General Household Survey 1980. No equivalent figure was available for Newfoundland

TABLE 4:5 Subjects' Marital Status, by Location and Sexual Status

Marital Status	Location and Sexual Status					
	Edinburgh			Newfoundland		
	female	male	total	female	male	total
Single	4	12	16	4	15	19
Married	11	13	24	12	7	19
Separated	3	3	6	3	8	11
Divorced	1	3	4	0	0	0
Widowed	0	0	0	1	0	1
Total	19	31	50	20	30	50

The catchment area of the Royal Edinburgh Hospital, as described above, is predominantly urban and the Edinburgh subjects in this research came from urban backgrounds. In contrast, nearly 50% of the Newfoundland subjects came from non-urban backgrounds. Only 27 of the Newfoundland subjects lived in one of the major towns in the Province. Another eight lived in small towns or villages on the Avalon peninsula on which St John's is located. The remaining fifteen lived in small villages or 'outports' - most of these at some distance from any of the major towns.

TABLE 4:6 Newfoundland Subjects' Area of Residence

Area of Residence	
St John's	22
Other major towns	5
Elsewhere on Avalon peninsula	8
Elsewhere in Province	15
Total	50

The 100 subjects ranged in age from 17 to 63 with a mean of 35.9 years (Edinburgh mean = 38.4; median = 35.5: Newfoundland mean = 33.4; median = 29.00). This compares to a mean age of 44 years for first admission patients to the acute wards and 49.2 for all admissions to the Royal Edinburgh Hospital in 1979. (7)

It may be that those considered too disturbed to be interviewed and probably those with organic brain syndrome were older than the subjects interviewed. The sample average would also be lower because those over 65 were excluded. In addition, the mean age for the hospital as a whole is higher because it includes statistics on re-admissions to the hospital.

The subjects' ages are presented in detail in Tables 4:7 and 4:8. In the analysis, three categories are considered - 29 and under; 30-44 years and 45 and above.

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(7) There was no equivalent figure available for Newfoundland, although the median age of all patients admitted to all psychiatric hospitals in Canada in 1979-80 was 36 years

TABLE 4:7 Subjects' Age, by Location

Age	Location		
	Edinburgh	Newfoundland	Total
Under 20	2	4	6
20 - 24	7	10	17
25 - 29	6	12	18
30 - 34	7	5	12
35 - 39	8	6	14
40 - 44	4	2	6
45 - 49	2	3	5
50 - 54	4	5	9
55 - 59	8	2	10
60 - 64	2	1	3
Total	50	50	100

TABLE 4:8 Subjects' Age, by Sexual Status

Age	Sexual Status		
	female	male	total
Under 20	3	3	6
20 - 24	7	10	17
25 - 29	5	13	18
30 - 34	5	7	12
35 - 39	8	6	14
40 - 44	4	2	6
45 - 49	1	4	5
50 - 54	3	6	9
55 - 59	2	8	10
60 - 64	1	2	3
Total	39	61	100

The subjects' education level, measured in number of years of formal education averaged 11.12 and 9.19 in Edinburgh and Newfoundland, respectively. There are also differences in the educational systems in the two countries. For example, a person completing a high school education and continuing on to college or university would do so after 11 years in Newfoundland, whereas in

Scotland this would normally be after 13 or perhaps 12 years of school.

TABLE 4:9 Subjects' Education Level, by Location

Education	Location		
	Edinburgh	Newfoundland	Total
0 - 9 years	12	23	35
10 - 13 years	25	15	40
Some college	7	9	16
Some university	6	3	9
Total	50	50	100

The higher proportion of male to female subjects in the Royal Edinburgh Hospital (31 : 19) contrasts with the admission statistics for the hospital as a whole. In 1979 only 45% (8) of patients admitted to the Royal Edinburgh Hospital were males and a similar proportion might have been expected in the sample. This disparity indicates either that more females than males during the research period did not meet the criteria for selection, that is they were over 65 years old, were normally resident outside the catchment area or, less likely, had organic brain syndrome or were admitted through the judicial system, or that more females than males were not interviewed for other reasons, such as refusing, being too disturbed, or discharging themselves before an interview could be conducted.

(8) The national rate was also 45%. The proportion of male first admissions to the acute wards was even lower at 42%. (All statistics specifically relating to the acute admission wards in the Royal Edinburgh Hospital are based on figures from 1 February - 1 December 1979)

The proportion of males to females in the Newfoundland sample (30 : 20), however, was similar to that of all admissions in the Province. (9)

The subjects' previous experience of psychiatry was thought to be a possible influence on attitudes. Those who had had psychiatric out-patient treatment themselves or who had family members or friends who had received psychiatric treatment were considered to be 'high' on experience. Those who had had minimal or no contact with such people were considered to be 'low' on experience. This distribution is shown in Table 4:10.

TABLE 4:10 Psychiatric Experience, by Location

Psychiatric Experience	Location		
	Edinburgh	Newfoundland	Total
High	23	27	50
Low	27	23	50
Total	50	50	100

These subjects had generally been admitted to hospital with a 'working diagnosis' and complete documented details of these were not yet always available. The information used here is taken from a combination of the subjects' own responses, their case notes and details obtained from the psychiatric and/or nursing staff.

Of the subjects admitted with specific diagnoses, two were suffering from post-puerperal depression, two were heroin addicts, one was manic-depressive and another had anorexia nervosa. These

(9) In 1980 (based on separations) 60% of first admissions and 53.5% of all psychiatric admissions in Newfoundland were male. The equivalent national figure for 1979-80 (based on admissions) was 58%. Separate statistics for Waterford Hospital and the Health Sciences Centre were not available

six, all Edinburgh subjects, were aware of these diagnoses. Three subjects had been admitted to Waterford Hospital for problems which were essentially behavioural and another two were considered possibly to be manic-depressive. An additional two Newfoundland subjects were thought to have problems with addiction to prescription drugs.

Twenty-eight of the 100 had been admitted to hospital because of problems with drinking or drinking and drugs. Another four, with a diagnosis of depression were considered likely also to have such problems - incidents involving alcohol having apparently precipitated their psychiatric admissions.

One Newfoundland subject had been admitted to hospital primarily to have her medication for seizures monitored. One from Edinburgh was considered not to have a problem at all and had been admitted to hospital (after a drug overdose) in order to secure her safety from her husband who himself had been a patient in the hospital. The remainder were suffering from depression and/or anxiety and/or physical complaints thought to have a psychological basis.

As can be seen from Tables 4:11 and 4:12 a much higher proportion of males than females had been admitted to hospital because of alcohol or drug related problems. The majority of females in both countries were suffering from problems identified as depression or anxiety.

It must be noted that because these subjects had just been admitted to hospital, the diagnostic procedures had not been completed and that a number were thought to be suffering from more than one of these problems. They have been classified here according to the first or main problem or symptom identified.

None of the subjects in this research had a diagnosis of schizophrenia. This, as was discussed in Chapter 3, is because of the way the sample was selected. Patients considered 'disturbed' - and this included those suffering from delusions and/or hallucinations - were not interviewed.

TABLE 4:11 Edinburgh Subjects' Diagnoses/Presenting Symptoms, by Sexual Status

Diagnoses/Presenting Symptoms	Sexual status female	male	Total
Depression/anxiety	10 (52.6%)	15 (48.4%)	25
Post-puerperal depression	2 (10.5%)	0	2
Manic-depression	0	1 (3.2%)	1
Anorexia nervosa	1 (5.3%)	0	1
Physical problems	1 (5.3%)	1 (3.2%)	2
Alcohol (alcohol and drugs)	2 (10.5%)	13 (41.9%)	15
Depression/possibly alcohol	1 (5.3%)	0	1
Heroin addiction	1 (5.3%)	1 (3.2%)	2
No problems	1 (5.3%)	0	1
Total	19 (100%)	31 (100%)	50

TABLE 4:12 Newfoundland Subjects' Diagnoses/Presenting Symptoms, by Sexual Status

Diagnoses/Presenting Symptoms	Sexual status female	male	Total
Depression/anxiety	15 (75.0%)	9 (30.0%)	24
Manic-depression (possible)	0	2 (6.7%)	2
Physical problems	2 (10.0%)	0	2
Alcohol (alcohol and drugs)	1 (5.0%)	12 (40.0%)	13
Prescription drug problem	0	2 (6.7%)	2
Depression/possibly alcohol	0	3 (10.0%)	3
Behavioural problems	1 (5.0%)	2 (6.7%)	3
Medication monitoring	1 (5.0%)	0	1
Total	20 (100%)	30 (100%)	50

All of the Edinburgh subjects had been admitted on an informal basis with one exception. This compares to 6% of first admissions to the acute wards on a compulsory basis and 7.5% for all admissions to the Royal Edinburgh Hospital (10) in the same year.

Six of the 50 Newfoundland subjects (all in Waterford Hospital) had been admitted on an involuntary basis. This compares with 33.5% of all admissions to Waterford Hospital in that year. The Health Sciences Centre Psychiatric Unit only very rarely admitted patients on an involuntary basis. (11)

That there were fewer compulsory or involuntary subjects interviewed than would have been expected from the statistics for the hospitals as a whole may not be surprising. Many of those not interviewed because they were too disturbed or because of having been admitted through the judicial system, would have been admitted to hospital on a compulsory or involuntary basis. This latter condition is particularly relevant in the case of Waterford Hospital where a considerable proportion of the 33.5% of admissions would have been admitted under the Criminal Code.

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(10) The equivalent in 1979 for all admission to psychiatric hospitals in Scotland was 8%

(11) Hoenig et al (1982) calculate involuntary admissions as rates of all psychiatric admissions in Newfoundland in 1978 as 6.8%

CHAPTER 5

Self-Conceptions and Conceptions of Mental Illness

This chapter considers the subjects' views of their own problems and of mental illness generally and the ways in which they interpreted their own problems and defined themselves as patients in relation to their general conceptions of mental illness. Following from the discussions in the literature, two issues are of particular interest here. One concerns the stereotype of mental illness and the mentally ill and whether people being admitted to hospital for the first time describe in a negative way this condition. The other issue is whether these subjects identified themselves or their own condition with 'mental illness' or the 'mentally ill', and if not how they described their own problems.

If the critics of labelling theory are correct in that mental illness is no longer considered in a negative way, then we would not expect these subjects to describe mental illness and the mentally ill in terms of a stereotype. In addition, if the claims of critics such as Gove are valid, then we would expect these subjects to identify their own conditions with their conceptions of mental illness without considering them negatively. This would be consistent with the requirements of the patient role, according to sick role theory, whereby acceptance of oneself as ill and in need of help is a pre-condition for successful therapy.

On the other hand, if labelling theory is valid we would expect evidence of negative stereotyping regarding 'mental illness' and 'the mentally ill'. In addition, if we take what has been described as a deterministic model of labelling (Scheff's version), we would also

expect the subjects to identify themselves with this stereotype.

However, other studies of such issues with patients report findings which do not clearly support either a labelling or a psychiatric/sick role perspective. As was seen in Chapter 2, some studies show that patients think of mental illness negatively but view their own problems positively. Other research indicates that mental illness is not considered in a stereotyped way but rather in terms of a medical conception. Patients may differentially interpret the label of mental illness.

Thus this chapter is concerned with the ways in which the subjects in the present research described mental illness and how this relates to their understanding of their own conditions.

Conceptions of Mental Illness and Characteristics of the Mentally Ill

To obtain information on this, the subjects were asked 'What is mental illness?' and 'What would a person be like if they were mentally ill?' Similarly, they were asked what they thought a person would be like 'if they had problems with nerves?' One other question was asked with the aim of obtaining more information on the perceived behavioural characteristics of the mentally ill as well as to consider whether or not stereotypes associated with the mentally ill were held by these subjects - 'Could you tell if a person were mentally ill if you didn't know them, and, if so, how?' (1)

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(1) A similar question was used by Townsend (1978)

In using the terms 'nerves' and 'mental illness' [2] it was thought that a range of perceptions of problematic behaviours would be obtained. The introduction of the term 'nerves' in this way might be considered problematic in that a disorder might have been implied and 'nerves' need not necessarily denote a disorder but may be considered a personality type.

It is considered, however, that the use of 'nerves' and 'problems with nerves' did not in fact direct these subjects to consider it as a psychiatric disorder. Their definitions of this term, as will be discussed below, did in fact range from a 'normal' personality type, one which was contrasted with problems considered to require psychiatric care, to a problem equivalent to 'mental illness' and a less stigmatised term for the same disorder.

It would have been possible, of course, to ask the question directly of whether or not 'nerves' was a condition that needed to be treated by a psychiatrist. However, the main aim here was to investigate these subjects' understanding of 'mental illness' and 'nerves' was introduced as a contrast and not a central focus of interest. Given the range of responses elicited in this research to the meaning of 'nerves', it might be of interest for future research to direct a variety of questions to the use of this term.

Similarly, these subjects were not directly asked if the status of 'mental illness' lasted over time. This also, it emerged, might have been of some interest, particularly with regard to the question

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(2) Other terms were introduced in a similar way but responses to these were not as varied as was expected and are not considered here. The terms were 'mad/insane', 'slow', 'simple', 'sensitive', 'over-emotional', 'highly strung', 'neurotic' and 'high and low spirits'. Subjects in Newfoundland were also asked about 'foolish', 'down', 'stunned' and 'retarded'. These were included after consultation with experts on Newfoundland culture - a sociologist, an anthropologist, a specialist in education and a psychiatrist

of stigma. This too would be a useful question to address in future research.

In response to the questions on the nature of mental illness and the identifiable characteristics of the mentally ill, some subjects gave descriptions of behaviours, others spoke only in terms of the seriousness of the illness and some gave their ideas on both. Their responses fell into the following categories:

(a) Mental illness was considered only to be associated with bizarre, dangerous or unpredictable behaviour. It was thought to be essentially non-understandable

(b) Mental illness was associated only with conditions such as depression, anxiety or nerves. This tended to be perceived as understandable although not necessarily as 'normal'

(c) Mental illness was associated with both of these descriptions. It was considered to apply to conditions characterised by bizarre, dangerous or unpredictable behaviour as well as to conditions such as depression, anxiety or nerves.

Not all of the subjects in this research described mental illness in these ways. In addition there were a few who:

(d) either did not clearly conceptualise mental illness and/or gave insufficient information for their opinions to be analysed.

(a) Subjects who Viewed Mental Illness as a Condition Characterised by Unpredictable, Bizarre or Dangerous Behaviour

This category included subjects who said that the mentally ill were violent, or potentially so, and a danger to other people and themselves. Not included in this, however, are those who said that the mentally ill were suicidal and associated this with depression rather than dangerous or unpredictable behaviour. Also included are

those who said that the mentally ill would be 'out of control', might exhibit unpredictable or bizarre behaviour, who hallucinated or who were confused in the sense of being disoriented.

The descriptions in this category approximate the stereotype frequently discussed in the literature. Scheff (1966:82) argues that it is in terms of this stereotype that people tend to react to the deviant.

Violence - the most extreme aspect of this stereotype - was associated with the 'mentally ill' by several subjects. This is seen in the following quotations:

> Well that's (mental illness) the mind. To me it's a bad thing. It could damage other people, never mind the person who had it. It's a disorder of the brain. It would depend on the situation they found themselves in when it sort of came over them. They could do themselves damage and they could maybe do somebody else damage.

> Well somebody probably throwing chairs at people and getting a knife and chasing them or getting a gun and chasing them, running and jumping over a cliff and drowning myself, or anything like that I guess.

As was seen in the review of the literature, a number of early researchers found that the central characteristic of conceptions of mental illness was unpredictability (Cumming and Cumming, 1957; Nunnally, 1961; Maclean, 1968). This negative stereotype - discussed by proponents of the labelling perspective - seemed to be a dominant theme of some subjects in the present research.

'Unpredictability' need not necessarily be associated with violence. It may encompass generally annoying behaviours particularly those where acceptable rules of social interaction are not followed. It may also

include behaviour of a generally bizarre nature. What is central to the examples given here is the non-understandability of such behaviours to the observer. In this way deviance from social norms was equated with illness. As Horwitz (1982) pointed out, all societies appear to have a stereotype of mental illness which is based on behaviour which breaks such norms relating to interaction.

Generally incomprehensible and bizarre behaviour was described by one subject in discussing an incident from his past experience in order to explain his ideas on mental illness.

> I suppose when I used to work in George IV Bridge Library, he (another reader in library) always had this crazy hat with trousers up to here and he'd sit and he'd suddenly leap from his seat and grab a great massive atlas and hurl it down on the desk and shout. Well I reckon he was mentally ill.

Still other subjects emphasised the failure of the 'mentally ill' to acknowledge legitimate social expectations in terms of their exhibiting a lack of control and being irresponsible. For example one male subject described a mentally ill person in the following way:

> Well you go up, well you crack a joke with somebody and he goes off and beats your face off or something like that, he just blacks out. Just goes at you altogether and he won't stop and he don't care what he does and he don't care where he goes. He just don't give a damn, never bothers to think of it after. It don't bother him and he really don't realise.

Confusion for these subjects was also more generally associated with the 'mentally ill' being unaware of what they were doing. This aspect is illustrated in the following description:

> Well they wouldn't maybe know what they were doing half the time and forgetting lots of things, and things like that.

Another group of behaviours considered by some of these subjects to indicate mental illness concerned inappropriate behaviour or speech, as well as being generally disoriented. As with some of the descriptions above, these generally incorporated behaviours which were considered not to conform to routine interactional conventions. These included talking to oneself, laughing inappropriately, talking incessantly, not presenting oneself competently, having 'staring eyes' or other facial expressions, being agitated and being too friendly. Similar to this were statements which said that the mentally ill would not understand what was said to them, whose 'minds wander', who did things 'incorrectly', who might 'speak rubbish', would be unable to carry on a conversation or who would not make sense.

Despite the picture frequently portrayed in the media, delusional or grandiose personalities were not mentioned at all by any subjects in this research. Such a view tends to be included in discussions of stereotypes of mental illness. However such delusions tend to be associated with general paralysis of the insane - a condition now relatively rare as a result of treating syphillis with antibiotics. These subjects may have been aware that this condition is now rarely found and therefore did not describe the mentally ill in this way.

The same argument, however, could be applied to the perception of the mentally ill as dangerous - a view which, as Scheff (1966)

points out, tends not to reflect reality. Yet this idea was central to some of these subjects' beliefs about the mentally ill. It is possible that this aspect of the stereotype tends to be perpetuated because of a basic fear of the mentally ill - a fear which focuses on violence. It may also be reinforced in media accounts, such as newspaper articles which are not fictional and in which a person's psychiatric status may be mentioned and associated with acts of violence.

Some of the descriptions given by these subjects do reflect conditions or behaviours which might be exhibited by people suffering from certain psychiatric disorders. Schizophrenic illness, for example, does sometimes present behaviours which might be interpreted as incomprehensible and disruptive. Certainly some of the extreme behaviours which these subjects described as indicating mental illness were based on their experience of particular people or incidents. This is apparent in the following quotation:

> Well, when we were on holidays, there was this guy, by looking at him I knew there was something wrong with him. Like he had long nails and really long toenails. Well you know by talking to him, like he was in the war and he'd shoot, pretending to shoot at the T V.

It is the generalisations drawn from such examples which become distortions of reality and which both reflect and perpetuate a stereotype of mental illness. Other subjects, not apparently drawing from particular experiences, were employing a stereotype which is widely held by people generally.

Such descriptions of 'mental illness' and 'the mentally ill' were given by a high proportion of subjects in this research. It appears

widely held then that the 'mentally ill' were thought to be different from other people; that their actions were deviant, non-understandable and socially unacceptable. The descriptions given here are similar to those discussed in the literature on stereotypes and mental illness, in that they tend not to be clearly conceptualised and include a wide variety of inappropriate behaviours. In this it appears that these subjects may have been drawing upon the idea of a 'psychopathic personality' - a concept so broad that the 1975 DHSS Report of the Committee on Mentally Abnormal Offenders (Butler Report) argued it should be abandoned.

Although these subjects generally gave behavioural characteristics as indicative of mental illness, a few qualified the conditions under which such a hypothetical person could be recognised. For example, one subject characterised the behaviour of the mentally ill as violent, threatening and unpredictable, based on her experiences of her schizophrenic husband. To her, the signs of mental illness were obvious but she had found that others were unable to recognise this:

> Well as I say, if you looked at my man you wouldnae believe it. D' ye 'ken, it's hard. Some people can look so normal but underneath they could be the most wickedest person.

Most of these subjects, however, tended to think that the 'mentally ill' were readily recognisable by their behaviour.

Thirty subjects in this research responded to the question on the nature of mental illness and the behaviour of the mentally ill only in terms of these descriptions. A second larger group, who described mental illness and the mentally ill in similar ways but also said they thought mental illness applied to a much wider variety of

conditions and could also be less serious, less deviant and understandable, will be discussed in the third category (c).

(b) Subjects who Viewed Mental Illness as a Condition Characterised by Depression, Anxiety or Nerves

Twenty six subjects did not employ stereotyped images when discussing the nature of mental illness or characteristics of the 'mentally ill'. Mental illness was considered by these subjects to be associated only with conditions such as depression, anxiety or 'nerves'. Their conceptions were solely based on neurotic-type disorders. This contrasts with the descriptions above where mental illness and the 'mentally ill' were considered to be essentially non-understandable. These subjects tended to see depression and other emotional problems as something either with which they were personally familiar or as a more extreme form of emotions experienced by everyone in normal life.

Although the psychiatric profession does not always agree on the distinction between neurotic and psychotic illness, these subjects appear to have incorporated such a distinction into their understanding of psychiatric disorder. The Ninth Revision of the WHO's classification of mental disorders defines neurotic disorders as follows:

> Neurotic disorders are mental disorders without any demonstrable organic basis in which the patient may have considerable insight and has unimpaired reality testing, in that he usually does not confuse his morbid subjective experiences and fantasies with external reality. Behaviour may be greatly affected although usually remaining within socially acceptable limits, but personality is not disorganized. The principal manifestations include excessive anxiety, hysterical symptoms, phobias, obsessional and compulsive symptoms, and depression.
> (1978:35)

It is this type of condition which these 26 subjects gave as their only conception of mental illness.

Depression varies in severity both in clinical terms and in the perceptions of these subjects. However, although it was not considered to be 'normal' and non-serious it was seen as fairly understandable. Depression or 'feeling depressed' are terms used in everyday conversation to describe affect but the difference between an illness and a 'mood' was stressed by one female subject.

> Well I see it (mental illness) as a feeling that comes over you, you know. As I say, it's hard to anyone who's never had it ... There was a girl off a few weeks ago and the doctor put acute depression and I knew that was a lie and I knew she was off because her boyfriend was home. And I immediately said, 'She wouldn't kid about it if she knew what it was about'. And now I know what it is. When people turn round to me and say, 'I feel really depressed', I immediately want to say to them, 'You don't know what you're talking about'. But some people, you get this, 'I'm awfully depressed', and really they don't know what they're talking about.

This woman was expressing the view generally held by subjects in this research that the problems from which they were suffering were serious enough to justify adopting the sick role and to be allowed exemption from everyday responsibilities. Misuse of the sick role, as in the above description, was seen as potentially invalidating their own experience of depression.

Generally depression was considered to be an illness in need of psychiatric treatment. But a fairly broad range of conditions was covered by this. For example at the 'mild-moderate' and 'understandable-normal' end of the spectrum, depression was associated with feelings of being 'down' or in some instances with

'nerves' although the term 'nerves' was also associated with a wide range of conditions and behaviours, and at the opposite end of the spectrum depressive symptoms were associated with being suicidal.

> Well you would expect them (a person who was mentally ill) to want to commit suicide, not want to face anything they've been involved in before, not want to associate with their friends, and just a feeling that they would, they have no desire to continue more or less.

Subjects who said that the mentally ill were characterised by an inability to 'think straight', by confusion of an emotional type, saw mental illness in a similar way to those who said it was characterised by depression. For some, these two symptoms were synonymous.

The other major perceived characteristic of mental illness in this category was an 'inability to cope'. By its definition, the need for psychiatric treatment was implied. Again, however, the range according to degree of seriousness was quite broad. At one extreme it was:

> People get their problems, just unable to cope with them.

At the other extreme it was associated with suicidal tendencies.

> You maybe tried to commit suicide, and, because you just couldn't cope with normal everyday things, using normal as accepted by the majority of people.

People who were 'mentally ill' in this way were not considered to be recognisable to the extent that those more seriously disordered and described in terms of the stereotype discussed above were - primarily because that stereotype was characterised by observably deviant

behaviour. However indications of mental illness were thought by some subjects to be appearing withdrawn, not talking, thinking constantly, not wanting to be with others and simply appearing unhappy.

Many of these subjects qualified the conditions under which the 'mentally ill' could be recognised. Some said it depended on the situation or on possible reactions of the person in question. Others said such recognition would be possible after observing them for a period of time and others thought they would need to know what the person was like 'normally'. Others were ambivalent. For example, one female subject said she thought she might be able to recognise this but that others had not known that she was ill.

> Yes, I think so. They might refuse to recognise it themselves if you said it but I think there are things. If I saw somebody worrying an awful lot about something that I don't think is worth worrying about, I would be careful. If I saw somebody getting very very upset about something ... I mean it's easy to say that now I'm here. But when you have never been here you don't think quite in these terms. Because I know one of my friends when she found out that I was here she couldn't believe it. She said, 'Gosh, I knew you were worrying but I didn't think anything was ...' But me feeling the way I was feeling if I'd seen somebody like that I probably would have thought of this but she didn't because it would have never entered into her head.

Mental illness was also associated with 'nerves', 'being nervous', 'breakdown', 'emotional' and 'uptight'. Some subjects used the terms 'mental illness' and 'nerves' synonymously.

> Got a nervous illness. You imagine they'll be jumpy, and bite their nails a lot, this kind of thing, jumpy. A lot of people are in here for nerves, nervous breakdown.

More Newfoundland than Edinburgh subjects equated the two terms in this way. This does not necessarily mean that Newfoundland subjects saw mental illness as less serious. In fact Newfoundland subjects seemed to see 'nerves', when associated with the term 'mental illness', as a serious condition requiring hospitalisation.

In general, where 'nerves' was associated with the behaviour of the 'mentally ill', such a person was thought to be identifiable by appearing 'on edge', 'shaky', 'nervy', had a 'tendency to drop things', would appear 'insecure', 'tearful' or anxious. They were also said to be recognisable by appearing 'panicky', 'worked up' or by temper loss.

Even where 'nerves' was not considered to be an illness, it was thought by these subjects to manifest itself in similar behaviours and problems.

> It means they're on edge, tense. Anything from tense socially, wanting to be more relaxed, to somebody who's obviously ill at ease, self conscious, appearing nervous.

Where it was seen as a personality trait it was thought not to seriously impair the person's functioning and was considered to be amenable to treatment, particularly by the prescribing of medication, from GPs.

This group of subjects stressed the 'internal' nature of mental illness more than those in the first category and in general denied that it was possible to recognise a 'mentally ill' person. This is seen in the following:

> I don't think so. I don't think it's possible for anybody to know how bad a person is. It's something that happens inside a person. Nobody, it's something that's deep inside.

(c) Subjects who Viewed Mental Illness as Encompassing a Wide Variety of Disorders

Thirty seven of the subjects described mental illness so as to encompass both extreme , unpredictable and non-understandable behaviours as well as more understandable disorders basically of a neurotic type. Their responses in terms of descriptions of mental illness and the mentally ill were similar to those of the subjects in both categories discussed above. To many of these subjects, the 'mentally ill' were thought to be recognisable only in extreme cases or if the illness were serious.

(d) Subjects who did not Clearly Conceptualise Mental Illness

The remaining subjects were not clear about what they thought mental illness was. Most of these subjects appeared to think that the behaviour of the 'mentally ill' was abnormal and inappropriate but were not clear about expressing this. They tended to say that it was not possible to tell if a person were mentally ill because their behaviour could be confused with things such as taking drugs or being mentally or physically handicapped. One subject said that he might think 'they were not the full shilling' and another thought he might conclude 'he was a bit weird'. All of this seems to indicate a confusion of various disorders. These subjects did not make clear distinctions between mental illness, handicap and what might be considered as eccentricity and hence appeared to confuse conditions

amenable to psychiatric treatment and those that are not.

The Meaning of 'Nerves'

As was mentioned above, these subjects were also asked what they thought characterised a person 'who had problems with nerves'. This might have been taken to imply that 'nerves' was a disorder and not a description of a type of personality. The subjects in this research in fact varied as to whether they thought of it as an illness or not. Indeed there was some overlap between the two.

As was seen in the discussion of the second category, some subjects used 'nerves' and 'mental illness' synonymously. This was found particularly among Newfoundland subjects. This contrasts with Dinham's (1977) general findings about the use of the term 'nerves' in outport Newfoundland. He found that the label 'nerves' tended to be used as a justification for not identifying a person as mentally ill. He also found some overlap between the two terms but 'nerves' was not considered to be a serious condition. Among the subjects from Edinburgh, there was a clearer distinction between the two terms. These two views can be seen in the following statements - the first from an Edinburgh subject.

> I think that's (mental illness); something more deep rooted than just nerves, something that is actually, I find that difficult to put into words, but you know, it's a deeper problem than nerves.

This contrasts with a Newfoundland subject's definition of both terms.

> Mental illness: mental illness refers back to your first term (nerves), as far as I'm concerned, and I would have the same reaction.

> Nerves: gosh, they should go and do something about it ... Well (they would be) obviously extremely distressed about some reason or another ... that's terrible, that's too bad.

A number of subjects in this research identified their own condition or problem as 'nerves'. In some cases this specifically referred to identifiable symptoms. Many of those who had been admitted to hospital because of problems with drinking mentioned having felt 'nerves' or 'nerves in the stomach'. Others used the term more generally to describe their own problem of depression or anxiety. This was particularly noticeable among those subjects described above in the first category who tended to utilise stereotyped imagery when discussing the 'mentally ill' and who also tended to deny the label 'mental illness'. These subjects, like those in Dinham's (1977) study, were apparently using a preferred and less stigmatising label to apply to themselves.

However, a great many subjects in both Edinburgh and Newfoundland used 'nerves' to mean either a milder condition for which hospitalisation was not considered to be necessary and which could be dealt with by GPs or to indicate a personality type, not necessarily requiring any medical or psychiatric treatment. Descriptions of 'nerves' when considered in this way were similar in both locations. The following is typical:

> Well the first thing it conjures up of course is that they're jumpy about something, their nerves are all on edge, that's the general idea of nerves. If someone jumps, they're always jumpy at a noise, or a gunshot or a car backfiring or something. That's what gives the impression to most of us as nerves.

For some 'having problems with nerves' meant having a problem but still being able to cope, while mental illness was characterised by being unable to cope. Others said that 'nerves' was a cause of mental illness or a stage in the illness progression.

'Nerves' elicited the greatest variety of responses of the terms specifically asked about in this research (other than 'mental illness') and unlike the other terms, it held a variety of meanings to these subjects. It primarily offered a contrast for their conceptions of mental illness, but of interest was its use as a preferred label for the subjects' own conditions.

Alcoholism and Mental Illness

One interesting feature of the responses to these questions is that very few subjects discussed alcoholism in relation to their conceptions of mental illness. It may be that had they been asked directly, these subjects could have considered alcoholism to be 'mental illness'. However their responses, or lack of them, might not be considered surprising given the ambivalent position of psychiatry vis-a-vis drug and alcohol dependence. For example, additions to the definitions of 'mental disorder' in both the Mental Health Act 1983 and the Mental Health (Scotland) Act 1984 state that no one should be treated under the Act(s) as suffering from mental disorder 'by reason only of ... dependence on alcohol or drugs'. On the other hand, problems of dependency are treated in psychiatric hospitals and these subjects generally appeared to be aware of this. Moreover many of them had themselves been admitted to hospital for such problems and in fact some defined themselves at times in the interview as 'mentally ill'.

However, they may have been ambivalent about such a definition of their problem - an ambivalence seen elsewhere in this research.

The Subjects and their Self-Conceptions

These 100 subjects, then, fell into three main categories when asked to describe 'mental illness' and 'the mentally ill'. They were as follows:

TABLE 5:1 Categories of Mental Illness Conceptions

Mental Illness Conceptions	No
(a) Stereotype	30
(b) Depression/anxiety	26
(c) Both	37
(d) Not coded	7
Total	100

Arguments in the literature, then, that the mentally ill are no longer considered in a negative and stereotyped way are not supported by the descriptions given by the subjects in this research.

Of particular interest here, however, is how these subjects considered themselves in relation to their beliefs about mental illness. The data on their self-conceptions were drawn from their responses to a number of questions. They were not asked directly if they considered themselves to be 'mentally ill' as it was thought that this might be threatening. However, they were asked if they thought of themselves as 'ill', what they thought their main problem was and what led to their psychiatric admission.

Their views on their own conditions were not always clearly conceptualised. A small number, such as those who had been diagnosed

as 'manic depressive' or 'anorexic' were aware of such diagnoses. Others identified their own problems as 'depression', 'drinking', 'anxiety', 'nerves' or 'feeling down'. But identification of their problems in this way did not necessarily mean that they considered it to be a 'mental illness' or symptomatic of such an illness. Nevertheless this does not mean that they did not consider that they themselves were suffering from a psychiatric disorder. Only a very small number of subjects in this research denied that they had an emotional problem of some sort.

Some subjects did clearly think of their own problems as 'mental illness', some were ambivalent about this and others clearly rejected this as being an appropriate description of their own condition. Yet even where this was rejected, this did not necessarily mean that they did not consider themselves to be 'ill' or to have a problem which warranted psychiatric attention.

Two points of interest emerge here concerning the first group of 30 subjects: (a) these subjects gave a stereotypical view of mental illness similar to that described in much of the literature on attitudes to mental illness; and (b) they did not think of themselves as and/or did not wish to be considered as 'mentally ill'.

Some of these subjects extended this 'denial' and did not apparently associate other patients with the term 'mental illness' or with their descriptions of the 'mentally ill' and identified what they and these other patients had as 'nerves' or 'depression'. This is illustrated by one subject describing other patients when asked if he thought they were mentally ill.

> Not mentally, they're not sick, no. Just probably depressed a little bit. There's nobody mentally sick and I've met everybody on the ward.

A similar view, this time extended to 'mental patient' can be seen from another subject's description of the ward.

> Everyone is free and there's no mental patients in here. It's just people with some pressures and so, like me, we all got our pressures, you know, or we wouldn't be here.

In this category five of the 30 said they did not think they had problems at all and another two said they only wanted a 'rest' and did not think they were ill. The rest, however, although they did not see themselves as 'mentally ill', and rejected the stereotype which they used to describe 'mental illness', did admit to having a problem whether it was with 'nerves', 'drinking' or 'feeling bad'. It would appear then that denial of mental illness does not necessarily mean denial of illness per se, or as will be seen later, rejection of the sick role.

The literature on attitudes to mental illness suggests different explanations for these types of responses. Some of this literature has found that the public hold broader views of psychiatric disorder than only that which is identified as 'mental illness'. This may be reflected in these subjects' views. The use of the term 'mental illness', as was suggested in Chapter 2, may have been a confounding factor in this, as in other research.

Alternatively it may be that these subjects held two cognitively distinct sets of ideas: a conception of psychiatric disorder which they applied to themselves and to the other patients on the ward; and a stereotype which they applied only to other more seriously ill patients and/or in the abstract as a contrast to their own condition.

The subjects in this research were not given a stereotype of mental illness to consider in relation to their views on their own condition. They themselves presented 'the mentally ill' in this way. It seems likely, given that they themselves had recently become psychiatric patients, that they were using their descriptions of mental illness as a way of dealing with a potentially stigmatising identity. Thus, their expressed conceptions of mental illness reflect responses to the possibility of being labelled themselves.

The subjects in the first category appear to have invoked stereotypical and negative images of mental illness and the mentally ill as a contrast to their own and their fellow patients' conditions. Rejecting a stereotype of mental illness may be a 'normal psychological process' as O'Mahony (1982) argues, but it may also serve the purpose of normalising one's own condition or illness. It serves to impress that one is not to be considered as unpredictable and dangerous - characteristics which these subjects ascribed to the truly 'mentally ill'.

Of the three categories of conceptions of mental illness this would appear to be the clearest statement of 'denial'. It may be that it was expressed by those most concerned not to be labelled as mentally ill by others but who at the same time felt most at risk of this happening.

The subjects in category (b) - those describing mental illness and the 'mentally ill' in terms of depression, anxiety or nerves were apparently not concerned with denying the label of 'mental illness' in the same way as those in category (a). Most, although not all, of these subjects tended to identify their own condition or problems with

expressed conception of mental illness and in fact based their illustrative examples on their personal experience. Not surprisingly, considering the high level of self-identification, while their descriptions of mental illness and the mentally ill were not as extreme as those of the subjects in the first category, these subjects did not deny that mental illness was still an incapacitating problem. Mental illness was characterised in the following way by one female subject.

> Something like myself, I guess. I get depressed. I can't drive a car. I can't cope with nothing. My speech slows down. I don't want to answer the telephone. I don't want to see anybody.

Four of these subjects stated that their main problem was with drinking. The rest said they were either suffering from depression (including one who had been admitted because of drinking problems) or from some other emotional problem relating to anxiety, 'nerves' or exhaustion. Eight of these 26 had been admitted to hospital after a suicide attempt and these subjects in particular focussed on their own problem or situation in expressing their conceptions of mental illness.

Although these subjects did not use stereotyped images of the mentally ill and it is not known how they would have responded to questions incorporating stereotypes, there is some evidence that they would have rejected them both in relation to themselves and to the 'mentally ill'. Such evidence can be seen in the following quotation.

> I'll never forget his words. I'm usually a very quiet person and I don't speak out. And he came up with a grand explanation - 'You can always tell a person who's been in the mental hospital or has emotional problems', he says, 'by their looks, the look on their face'. Well, I mean, that was the one time I went right at him, not physically but verbally. I could look at you, you could have come out of the asylum, how do I know? I can go up to K-Mart and might run into a hundred people and some of them might just be let out of one of the wards for a day to go shopping. How do you know? I mean, when you walk up to someone you don't know what they're like or how they react. What he said was just plain stupid, that you can tell a person with emotional problems, you know, just by their looks.

These subjects, in stating that mental illness was not characterised by visibly obvious deviant behaviour, were also apparently stressing that they themselves were not to be considered deviant.

This and the third category of conceptions of mental illness represent two alternative ways of dealing with the label of mental illness -neither of which involve denying the label in relation to one's own condition. In this case normalisation involves restricting the label of 'mental illness' to understandable behaviours and conditions. The subjects in this and the third category were probably less anxious about being labelled as mentally ill by others than were those in the first category. Or if they were, by indirectly applying the label to themselves and defining mental illness in a non-threatening way they may have been attempting to reduce the impact of such labelling.

The subjects in category (c) who included both extremes and unpredictable behaviours as well as neurotic disorders in their descriptions of mental illness and the 'mentally ill' tended also to

incorporate their own conditions into these conceptions. It is possible that such a perspective develops through experience and indicates a move in the direction of adopting a psychiatric frame of reference. Some of these subjects admitted that prior to their hospital admissions they had thought of mental illness only in stereotyped terms but had recently broadened their definitions. This was reflected in the following quotation.

> Well up until I came in here, the only ones I seen with mental illness is when I was working on the job and they were really mentally disturbed and right up to the violent stage. But now I've come in here and seen different views of it. Let's just say two or three months ago if anybody had said mental illness to me, I'd have said 'Oh Christ' and rattled off a few names of ones that were inside (prison), them that's going to Carstairs. (3) But since I came in, I say to myself, 'Am I mentally ill?' But then again there's ... (name) - just post-natal depression. There's that young girl. There's all types of mental illness.

Such a change in perspective need not necessarily occur on admission to hospital. It is possible that many of those who had received psychiatric out-patient treatment in the past had undergone a similar process if they had also come to perceive themselves as mentally ill at this stage. One such subject said:

> Since I've been around psychiatrists myself - before I thought it had to be something really bad, wrong upstairs, in order to have a mental illness. Well I thought you had to be a crackpot in order to see a psychiatrist. But I know they are not. You don't have to be that bad at all.

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(3) The State Hospital, Carstairs - a special hospital providing secure accommodation for patients considered to have dangerous, violent or criminal propensities

Of course it is possible that many of these subjects had developed a perspective of mental illness which encompassed a broad variety of conditions prior to their ever having consulted a psychiatrist or a GP about their own problems or even prior to their having a problem at all. Such a view could develop from experience with other people suffering from psychiatric disorders, reading about psychiatry or even from experience of media presentations on the topic. A considerable amount of media coverage in recent years has presented serious and informative accounts of psychiatric disorder. As will be seen in Chapter 7, the subjects in this research were apparently inclined to distinguish between fact and fiction. It is likely that some had drawn some understanding of the nature of mental illness from this.

Again presenting mental illness in this way may reflect attitudes - this time based on knowledge or experience of psychiatry. However it may also be seen as another strategy for dealing with a potentially stigmatising identity. As in the second category these subjects did not clearly deny the label of mental illness.

Redefining oneself as mentally ill is more acceptable if accommodations and expansions in the definition of mental illness, such as those illustrated above, are also made. They thus present their views on mental illness as 'enlightened' or as 'educated' and resulting from experience and knowledge. Such definitions may also be used to explain to the uninitiated (or unenlightened) why, although one may be mentally ill such an identification is not justification for discrimination or negative attitudes on the part of others.

Subjects' Characteristics and Conceptions of Mental Illness

The literature on attitudes to mental illness and on help-seeking behaviour indicates that some people are more likely than others to hold positive views of mental illness and the mentally ill. This, as was seen in Chapter 2, may vary with age, education, knowledge and experience of psychiatry, sex and social class.

In the current research, however, the subjects' views of mental illness were tied to their views of their own conditions and may be considered not only as attitudes but also as ways of dealing with the possibility of themselves being labelled as mentally ill. Nevertheless certain variables seem to be related to the views expressed.

The relationship between conceptions of mental illness and education level is presented in Table 5:2. This relationship is significant at the .01 level. It would appear that those with some university or college education were most likely to describe mental illness as a broad range of disorders (66.7%) and those with under nine years of formal schooling were least likely to portray it in this way (21.9%). These figures lend some support to the notion that education is associated with attitudes to mental illness and the mentally ill. However, the relationship between conceptions and education is less clear when the other categories are considered. Those with under nine years of schooling were more likely to consider mental illness as being only a neurotic disorder, but a similar percentage of subjects in the two other groups described it in this way. In addition, while the subjects with post-secondary education were least likely to use only stereotypes in characterising the

mentally ill, those with 10-13 years of schooling were most likely to do so (40.5%), closely followed by those with under nine years (37.5%).

TABLE 5:2 Subjects' Conceptions of Mental Illness by Education Level

Conceptions of Mental Illness	Education Level 0-9 years	10-13 years	University/ College	Total
Stereotypes	12 (37.5%)	15 (40.5%)	3 (12.5%)	30
Depression/anxiety	13 (40.6%)	8 (21.6%)	5 (20.8%)	26
Both	7 (21.9%)	14 (37.8%)	16 (66.7%)	37
Total	32	37	24	93

$x^2 = 13.727$, $df = 4$, $p < .01$

The totals here and in subsequent Tables are less than 100 because of the subjects not coded on 'conceptions'

It also appears from Table 5:3 that older subjects in this research (those 45 and above) were least likely to describe mental illness as covering a broad spectrum of disorders and most likely to consider it either in terms of a negative stereotype only or only as a neurotic disorder. In contrast, half of the youngest age group and about as many in the middle age group described mental illness broadly. This also lends some support to the existing literature which argues that young people are more likely to have positive views of mental illness.

TABLE 5:3 Subjects' Conceptions of Mental Illness by Age

Conceptions of Mental Illness	Age 29 and under	30-44 years	45 and over	Total
Stereotypes	11 (30.6%)	7 (24.1%)	12 (42.9%)	30
Depression/anxiety	7 (19.4%)	8 (27.6%)	11 (39.3%)	26
Both	18 (50.0%)	14 (48.3%)	5 (17.9%)	37
Total	36	29	28	93

$x^2 = 8.667$, df = 4, n.s.

Some interesting patterns emerged when occupational status was considered (Table 5:4). Manual workers were more likely to subscribe to negative stereotypes only than were non-manual workers (37.0% compared to 25.6%) and non-manual workers were more likely to describe mental illness as a broad range of disorders (51.3%). A similar pattern was found when subjects currently in employment were compared with those not in employment (Table 5:5).

TABLE 5:4 Subjects' Conceptions of Mental Illness by Occupational Status

Conceptions of Mental Illness	Occupational Status Non-manual	Manual	Total
Stereotypes	10 (25.6%)	20 (37.0%)	30
Depression/anxiety	9 (23.1%)	17 (31.5%)	26
Both	20 (51.3%)	17 (31.5%)	37
Total	39	54	93

$x^2 = 3.708$, df = 2, n.s.

TABLE 5:5 Subjects' Conceptions of Mental Illness by Employment Status

Conceptions of Mental Illness	Employment Status: Employed	Not Employed	Total
Stereotypes	12 (25.0%)	18 (40.0%)	30
Depression/anxiety	16 (33.3%)	10 (22.2%)	26
Both	20 (41.7%)	17 (37.8%)	37
Total	48	45	93

$x^2 = 2.73$, df = 2, n.s.

Females were equally divided into the three categories (Table 5:6). They were, however, more likely than male subjects to describe mental illness in terms only of depression or anxiety. This partly reflects the greater proportion of females in the sample suffering from such disorders. Male subjects more than female subjects encompassed a broad range of disorders into their descriptions of mental illness.

TABLE 5:6 Subjects' Conceptions of Mental Illness by Sexual Status

Conceptions of Mental Illness	Sexual Status: Female	Male	Total
Stereotypes	12 (33.3%)	18 (31.6%)	30
Depression/anxiety	12 (33.3%)	14 (24.6%)	26
Both	12 (33.3%)	25 (43.8%)	37
Total	36	57	93

$x^2 = 1.249$, df = 2, n.s.

Unmarried subjects were most likely to describe mental illness as a wide range of disorders (43.4%) and least likely to describe it only as a neurotic disorder - as depression or anxiety (22.6%) (Table 5:7). While the 'unmarried' category includes single (never married), separated, divorced, and widowed subjects, a large proportion of these were never married and of a relatively young age. Older subjects, as was seen in Table 5:3, least frequently described mental illness as a wide range of disorders. Thus, the findings for marital status are to some extent consistent with the findings for age.

TABLE 5:7 Subjects' Conceptions of Mental Illness by Marital Status

Conceptions of Mental Illness	Marital Status: Unmarried	Married	Total
Stereotypes	18 (34.0%)	12 (30.0%)	30
Depression/anxiety	12 (22.6%)	14 (35.0%)	26
Both	23 (43.4%)	14 (35.0%)	37
Total	53	40	93

$x^2 = 1.76$, df = 2, n.s.

With a chi-square value of 6.87 the relationship between location - that is whether a subject was from Edinburgh or Newfoundland - was significant at the .05 level (Table 5:8). Newfoundland subjects were more likely than Edinburgh subjects to use stereotypes only in discussing mental illness and the mentally ill. This may reflect cultural differences in terms of attitudes to mental illness or it may reflect different levels of anxiety about being labelled as mentally ill.

TABLE 5:8 Subjects' Conceptions of Mental Illness by Location

Conceptions of Mental Illness	Location Edinburgh	Newfoundland	Total
Stereotypes	10 (20.4%)	20 (45.4%)	30
Depression/anxiety	17 (34.7%)	9 (20.4%)	26
Both	22 (44.9%)	15 (34.1%)	37
Total	49	44	93

$x^2 = 6.87$, df = 2, $p < .05$

Actual experience of psychiatry was used as an explanation by many of these subjects for their understanding of mental illness as encompassing a broad range of conditions. Their experience, they argued, had led them to see mental illness in this way. However, when the 'experience' of all the subjects is considered, the influence of attitudes is less clear.

While those with a high level of psychiatric experience were more likely to subscribe to category (c) - to describe mental illness broadly (46.9%) over 30% of such subjects used only stereotypes in their descriptions (Table 5:9). High experience, however, is associated less with describing mental illness only in terms of a neurotic disorder.

Of course these views may depend on the nature of the experience rather than on its mere existence. Some personal experience, for example, may have been reason to be particularly concerned about the possibility of and the consequence of being labelled as mentally ill. Evidence for this will be considered below.

TABLE 5:9 Subjects' Conceptions of Mental Illness by Experience of Psychiatry

Conceptions of Mental Illness	Experience of Psychiatry Low	High	Total
Stereotypes	15 (34.1%)	15 (30.6%)	30
Depression/anxiety	15 (34.1%)	11 (22.4%)	26
Both	14 (31.8%)	23 (46.9%)	37
Total	44	49	93

$x^2 = 2.548$, df = 2, n.s.

Another variable which other research has linked to attitudes to mental illness is knowledge of psychiatry. An attempt was made here to gather information on this in the present research. However, inadequate data was elicited to be of use.

If the descriptions given by these subjects reflect not only positive or negative attitudes to mental illness but also responses to the identification of mental illness, we might also expect that views would vary among informal and compulsory patients. There were too few patients detained on a compulsory basis to be able to make such a comparison but feelings of being an 'unwilling' patient may have influenced attitudes. This will be considered below.

The subjects' views, it has been argued, not only reflect positive or negative attitudes but also their feelings about the label of mental illness being applied to them and their ways of responding to this. The use of stereotypes only may be the most explicit expression of denial and indicates anxiety about being labelled by others. The other two responses represent different ways the individual may apply the label to him or her self.

Labelling theory argues that people with greatest resources are

best able to resist hospitalisation (and therefore being labelled) and also that similar social factors or 'contingencies' are influential in decisions taken about their discharge from hospital. It seems that such factors in this research also influence the individual's response to hospitalisation and the possibility of being identified as 'mentally ill'.

Subjects here most inclined to use stereotypes only were those who had not attended university or college, those over 45 years old, manual workers and those not currently in employment. These subjects - those with fewest resources - were those who most clearly denied the label of mental illness as appropriate to their own condition and may be those most concerned about the consequences of being labelled by others.

Newfoundland subjects were also more inclined than Edinburgh subjects to use such stereotypes. This may reflect cultural differences or it may reflect anxieties about the consequences of the labelling process.

Conclusion

This chapter has considered the subjects' views of mental illness and how they interpreted their own condition in relation to these views.

The arguments in the literature relating to these issues are complex and the evidence in this chapter does not clearly support either a labelling or psychiatric/sick role perspective.

Firstly, while negative stereotypes - characterised by unpredictable, non-understandable and perhaps dangerous behaviour - were

associated with mental illness by these subjects, only a minority restricted the mental illness label to such stereotypes. A majority of these subjects thought of mental illness either in a benign way - as depression or anxiety - or presented a view which could be seen as approximating that of the psychiatric profession. These findings tend to lend support to critics of labelling theory who claim that mental illness is no longer thought of negatively.

Secondly, if the assumption is made that there is a 'correct' and 'enlightened' way to view mental illness, then it would be expected that factors such as experience of psychiatry and education level would be related to such views. Indeed it was found that there was a relationship between education level and expressed conceptions of mental illness. The experience of psychiatry was marginally related to the different descriptions of mental illness.

These issues must be considered in light of the fact that these subjects themselves had very recently been psychiatric in-patients and therefore were in a position of possibly being identified as 'mentally ill'. Their expressed conceptions, then, of mental illness may be seen as different ways of dealing with this potentially stigmatising identity.

These subjects used three different strategies. One group distanced themselves from the mentally ill and denied that they were mentally ill. They used only negative stereotypes in descriptions of mental illness - characterising the mentally ill as unpredictable, non-understandable and perhaps dangerous. In doing this they could distance themselves from the negative connotations associated with mental illness.

A second group did not associate mental illness with a negative stereotype at all and only acknowledged that it was a neurotic-type disorder - one not characterised by unpredictable or otherwise obviously deviant behaviour. Thus they could stress that they themselves should not be considered deviant.

The third group broadened the definition to include a wide variety of behaviours and conditions and presented it as an 'enlightened' view of mental illness. Thus they could explain why being identified as mentally ill should not be grounds for discrimination.

Some kinds of subjects were more likely than others to adhere to one or other of these points of view (or strategies). A higher level of education meant that subjects tended not to use stereotypes to describe the mentally ill. This could reflect an 'educated' and 'enlightened' perspective of mental illness (as they themselves present it and justify it). It may also be evidence of a lack of anxiety about being labelled as mentally ill and be consistent with labelling theory's claim that people with greatest resources are best able to resist labelling. Conversely some patients more than others described mental illness in terms of stereotypes only - older subjects, manual workers and those not currently employed. These may be those with fewest resources and perhaps those most concerned about the consequences of being labelled. That Newfoundland subjects also discussed stereotypes more than Edinburgh subjects may also reflect such anxieties or it may reflect cultural differences.

The relationship, then, between views of mental illness and actual self-conceptions is more complex than either the labelling or psychiatric sick role perspectives imply. Such complexity is suggested

by other empirical evidence on patient self-conceptions.

CHAPTER 6

Beliefs about the Aetiology of Mental Illness

This chapter focusses on the subjects' beliefs regarding the factors contributing to mental illness, the possibilities of intervention and outcome. To this end they were asked what they considered caused it, i.e. the reasons why a person might become mentally ill; what, if anything, could be done to prevent it, and whether it could be 'cured'. (1)

The literature on attitudes to mental illness, as was seen in Chapter 2, finds that the American and British public tend to think in terms of environmentally induced mental illness rather than in terms of hereditary or organic factors (cf. Elinson et al, 1967; Maclean, 1968; Townsend, 1978). Maclean (1968) particularly stressed this finding in relation to the Edinburgh public. It would be expected then that the subjects in this research would also emphasise such factors.

The subjects were asked to respond generally to the questions on aetiology and not specifically to focus on the causes of their own problems and illnesses. As in their descriptions of the nature of mental illness, however, their views on the causes of mental illness may also have reflected their attitudes towards their own conditions.

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(1) The questions asked did not distinguish between the possibility of 'cure' and 'recovery' in relation to mental illness. However, the subjects' responses indicated that such a distinction might have elicited a wider variety of opinions. Further research could address directly this and other related issues

The subjects' responses were examined first to identify their ideas on contributory or causal factors of mental illness. An analysis follows of themes emerging from their responses to the questions of causes or factors contributing to mental illness, the possibilities of intervention and outcome.

Perceived Causes of Mental Illness

The subjects' statements were first analysed to determine the numbers citing factors thought to contribute to or cause mental illness. There were four types of perceived causes. Under the heading of Social/Environmental are general stress or pressure; bereavement; other trauma or loss, such as losing a job or hearing bad news; financial problems; general environmental problems, such as bad housing conditions; failure; stress at work; problems with children; marriage problems and problems in other relationships. Alcohol and drug abuse and 'lifestyle' or behavioural problems, such as not socialising on a regular basis are grouped as Behavioural. Psychological includes being withdrawn; not discussing or disclosing problems; being preoccupied and abnormally anxious and having 'bad nerves'. Personality factors based on early socialisation and childhood are also incorporated here. Some of these 'psychological' factors, of course, are also symptoms of mental illness. However, a number of the subjects in this research discussed them specifically as causal factors and this is what is referred to here. Finally Physiological includes hereditary or congenital factors; a disease-like process; physical traumas, such as a 'bang on the head' or an automobile accident; childbirth or menopause. In discussing their

ideas on the causes of mental illness, the majority of the subjects referred to one or more of the above factors.

Eight subjects in Edinburgh and six in Newfoundland either said they did not know what could cause mental illness or they gave insufficient information to be coded. The remaining subjects cited the following as causes or factors contributing to mental illness.

TABLE 6:1 Subjects' Beliefs about the Causes and Factors Contributing to Mental Illness

Cause or Contributing Factor	Number of Subjects: Total (N = 92)		Edinburgh (N = 48)		Newfoundland (N = 44)	
Social/Environmental						
General stress/pressure	23		16		7	
Bereavement	10		8		2	
Other trauma or loss	10		7		3	
Financial problems	6		5		1	
General environmental conditions	3		3		0	
Failure/stress at work	3		2		1	
Marriage problems	4		3		1	
Problems with children	3		3		0	
Other interpersonal problems	8		4		4	
		70		51		19
Behavioural						
Alcohol or drug abuse	12		5		7	
General lifestyle	10		2		8	
		22		7		15
Psychological						
Withdrawal/obsession	25		14		11	
Childhood/upbringing	2		2		0	
Bad nerves	2		0		2	
		29		16		13
Physiological						
Congenital/hereditary	17		8		9	
Physical process (disease)	7		3		4	
Physical trauma	6		3		3	
Childbirth	1		1		0	
Menopause	1		0		1	
		32		15		17
Total causes or contributing factors cited		153		89		64
Mean cause cited per subject		1.66		1.85		1.45

In the current research, hereditary, congenital and other physiological factors were less commonly perceived causes of mental illness when compared to social-environmental factors. The former were referred to by 15 Edinburgh subjects but only one cited physiological factors alone. In other instances they were mentioned as only one possibility among many or as explanations for particular types of mental illness. Thus the Edinburgh subjects in particular were similar to Maclean's (1968) Edinburgh public and, indeed, to Townsend's (1978) American respondents.

It appears that Newfoundland subjects were more inclined than their Edinburgh counterparts to explain mental illness in terms of physiological factors in that 17 subjects cited these as causes of mental illness. Their ideas were perhaps more similar to those of Townsend's (1978) German respondents. However, social/environmental causes (and psychological and behavioural) were also commonly cited by these subjects.

'Withdrawing' or being obsessed by an anxiety were also frequently mentioned as a cause (as well as a symptom) of mental illness by both Edinburgh and Newfoundland subjects.

The subjects in this research, then, cited a variety of perceived causes of mental illness. This was in response to a general question regarding cause not specifically directed to what they considered caused or precipitated their own condition. Their responses to this general question of course may have been influences by their perceptions of their own problems. Social/environmental causes were most commonly cited by the Edinburgh subjects, followed by psychological then physiological (although the latter was cited as a

single factor only by one Edinburgh subject). Social/environmental, behavioural, psychological and physiological factors as perceived causes of mental illness were more evenly distributed among the Newfoundland subjects.

Aetiological Themes

The preceding discussion gives some indication of the subjects' beliefs regarding the causes of mental illness. However, when considered in conjunction with their ideas on the effectiveness of intervention, distinct themes regarding the aetiology of psychiatric disorder are apparent. Although many of the subjects cited a number of 'causes' of mental illness, most tended to stress one particular theme as the basis of their ideas. Of course the question of the aetiology of mental illness is complex and is surrounded by considerable debate within the psychiatric profession. Understandably the subjects in this research were not generally conversant with the range or complexity of this issue and tended to express only a few ideas. Six categories developed from these subjects' views were as follows:

(a) Subjects who considered that mental illness is either determined by congenital or hereditary factors and/or that it has a physiological basis and follows a process similar to that of a physical illness

(b) Subjects who considered that mental illness results from the impact of an external event or pressure and who thought that all individuals are equally susceptible to the effects of this

(c) Subjects who considered that mental illness results from the cumulative effect of events, pressures or situations and who thought that all individuals are equally susceptible to the effects of these

(d) Subjects who considered that mental illness results from the impact of events, pressures or situations and who thought that some individuals are more vulnerable that others to the effects of these external stresses and hence more susceptible to mental illness

(e) Subjects who considered that mental illness results from the individual's own psychological or emotional disposition

(f) Subjects who considered that mental illness results from a deviant lifestyle or behaviour.

In addition there were:

(g) Subjects who either said they had no opinion on the aetiology of mental illness or who gave insufficient information.

Although the majority of subjects subscribed to one of these six themes (a - f), ten placed equal emphasis on two themes. Their responses are included in the overall discussion of each theme but are discussed separately as:

(h) 'Multi-category' subjects.

(a) Subjects who Considered that Mental Illness has a Physiological Basis

Sixteen subjects either described mental illness in terms of disease - similar to a physical illness - or they stressed congenital or hereditary factors. Consequentially they tended to think of mental illness as a phenomenon over which the individual has no control. This view is illustrated in the following statement from a Newfoundland subject:

> It's just a sickness that can happen to you and can happen to anybody and there's nobody too good for it or anything. You know, it's just something that happens over the years. It can happen to the Pope or anybody like that.

The subjects viewing mental illness from this perspective tended to see it as something which could not be prevented. Where this was suggested as possible, the idea of intervention highlighted their views of its determinate nature. This can be seen in the following quotation:

> I wouldn't doubt it (that it could be prevented). If it was caught in the right time, before the thing gets out of hand. It's just like probably cancer, you know.

Viewing mental illness as due to hereditary or congenital factors, or drawing an analogy with a physical illness which occurs indiscriminately, serves to minimise individual responsibility for illness. It also, as in the first example above, allows for the denial of blame and the alleviation of guilt.

Of interest is that only two of the 16 who had been admitted to hospital because of problems with drinking - and both of these had been admitted under pressure - felt that they did not need treatment and wanted to be discharged. It is possible that having a problem with drinking, recognising that this is a problem and being admitted to a psychiatric hospital, is not consistent with equating mental illness and physical disease (despite the use of a disease analogy by AA and some psychiatric professionals). This is probably because of the feelings of individual culpability associated with drinking problems found to be a major theme in this research. It seems

unlikely that subjects with drinking problems would view these as being caused by hereditary or congenital factors..

Eight of the subjects in this category subscribed to more than one of the major themes emerging from the data. There are different possible explanations for this. It may be that they held two distinct ideas about mental illness and its causes and were distinguishing between what they considered to be two different syndromes. On the one hand, they thought that mental illness could be caused by hereditary or congenital factors or that it followed a process similar to that of a physical illness and, alternatively, they considered it could result from a different process altogether and it was this latter explanation which they themselves identified with.

Alternatively, they may have been stressing a denial of individual responsibility for illness. Six of the eight 'multi-category' subjects said that mental illness could also result from external pressures or stressful situations to which all individuals are equally susceptible - a perspective which also lends itself to a denial of individual blame.

It may also be that some of these subjects did not consider themselves to be 'mentally ill' and were not therefore including their own experience in their explanations. This will be considered below.

(b) Subjects who Considered that Mental Illness is Caused by an External Event or Pressure

As was noted in Table 6:1 a large proportion of subjects in this research said that mental illness was caused by events, pressures or situations - referred to as social/environmental factors. Thirteen subjects are distinct in that they considered that the impact of an

event or pressure could adversely affect individuals and, moreover, that all individuals are equally susceptible to this. They claimed that the event or circumstance determined the onset of mental illness and that nothing could be done to prevent it and that individuals affected were passive and reactive. In emphasising the impact of an event or a situation they are distinct from other subjects whose beliefs tended to revolve around the idea of stress, who emphasised the cumulative effect of a number of pressures. Central to the perceptions of the subjects in this category are the notions that: (i) all individuals are susceptible; (ii) for the individual it is incomprehensible and uncontrollable; and (iii) blame should not be attached to the individual.

Consequential to this, these subjects expressed the view that mental illness could not be prevented. One subject said:

> Not really (prevent mental illness). Because I think if you're going to have some sort of mental illness you're going to have it.

Traumatic events, particularly loss, were seen as leading directly to an illness:

> Maybe the bereavement, or the loss of a very close relative, the loss of one's earnings, the loss of one's love, the loss of anything you've held very dear to you.

This view is of interest in that the impact of life events on mental health has been subject to recent investigation. For example, Brown and Harris (1978) found causal links between unpleasant life events and depression in women and the major feature of these events was loss or disappointment (if this is defined broadly). The

possible adverse effects of such life events appears to have been recognised by the subjects in this category, although in stressing that anyone would be affected by loss they did not take into consideration factors of vulnerability, such as the lack of confiding relationships which Brown and Harris (1978) found to be important. Another group of subjects in this research did discuss the aetiology of mental illness in terms of vulnerability; these will be discussed below.

Only two of these subjects were pessimistic about the possibility of recovery from mental illness. The others considered that most people who were ill could, with treatment, make considerable improvement. Although these subjects denied individual responsibility with regard to preventing mental illness, a few emphasised the individual's importance in their own recovery. For example, one subject in response to the question regarding the possibility of preventing mental illness said:

> No, I don't think so. I think it would just happen anyway. I think an individual's mind is just something that nobody else can look right into.

But regarding recovery, she said:

> Yes, if, I think the cure really depends on themselves more than it does the treatment.

It seems likely, in saying that mental illness was the result of an event and an effect over which people have no control, that these subjects were stressing the view that the mentally ill person is not responsible and not culpable for his own condition.

Five subjects who subscribed to this view of mental illness also

said that mental illness could be caused by hereditary or congenital factors or that it followed a disease-like process. Despite viewing causation from two widely different perspectives, then, their ideas were consistent in the emphasis on a lack of individual responsibility. This was noted in the discussion of category (a). This denial was in fact a central feature common to all of the subjects in both these categories. The co-existence of similar beliefs was also found by Townsend (1978) among the German sample in his German/American comparative study. Those respondents saw mental illness as being both environmentally induced - and therefore transitory and curable - and as endogenous, chronic and determinate.

Perhaps surprisingly three of the subjects in this category had been admitted because of drinking problems and a further two were heroin addicts. It could be that in describing the causes of mental illness in this way they were justifying their drinking behaviour or drug addiction as a reaction to adverse life events. Alternatively, these subjects may not have been identifying the term 'mental illness' with their own problem and, like some of the subjects in category (a), were discussing their views about other people with other types of problems. This will be discussed below.

(c) Subjects who Considered that Mental Illness is Caused by the Cumulative Effect of Events, Pressures or Situations

Another perspective on the causes of mental illness expressed by subjects in this research was that it resulted from the cumulative effect of events, pressures or situations which adversely affected individuals and that all individuals are equally susceptible to such effects. This contrasts with the second category where single events

or situations not preceded by other adverse circumstances were perceived as adequate causes of mental illness. Specific events precipitating mental illness were perceived by the subjects in this category as triggering effects, as 'the last straw' rather than direct causes.

In contrast to the fourth category, where individuals were considered to vary in their susceptibility to the effects of social/ environmental factors, the subjects in this category described a process where a series of events or pressures would be deleterious to anyone no matter what personality traits or how much 'will power' they possessed. This view is expressed in the following quotation:

> Mental illness could be caused through, well it's like anything, the way anything goes, everyday life. Eventually you take so much and finally you just crack up.

This is somewhat similar to the engineering analogy which has, in the past, been applied to the relationship between stress and illness. One criticism of this approach, pointed to by, among others, Cox (1978:15), is that this stress-strain process is seen to function unconsciously and automatically and does not consider human recognition and interpretation of stress. In addition, Brown and Harris (1978) point out that the additive effect of life events has not been adequately tested. Nevertheless it appears to be a commonly held assumption - at least by 19 of the subjects in this research.

Mental illness was not considered by these subjects to be preventable except by reducing stress. One said:

> I think to avoid the strain, the stress and strain situation. To try and stop it before you reach it, if someone feels that the stress is becoming too much.

It was also seen as a condition which could continue to deteriorate without psychiatric intervention. These subjects also tended to be optimistic about the possibility of recovery from mental illness. For some, these views appear to reflect their perspectives on their own problems and their attitudes to their psychiatric admissions. Such acceptance of the benefits of psychiatric help was expressed by one subject as follows:

> Sure (it can be cured). Well like me, if I'd stayed at home, or all of us, if we all stayed at home and never came for help, naturally we would have all went crazy. So we came here for help.

This is similar to those statements made by subjects advancing an 'educated' perspective discussed in Chapter 5.

Again it is not clear whether or not these subjects were drawing from their own experience or their understanding of their own conditions in advancing their ideas on the aetiology of mental illness.

Six of the 19 had been admitted after a suicide attempt and they seem to have been expressing an opinion that increasing stresses had contributed to this. Four of the 19 had had treatment as psychiatric out-patients in the past and another three were admitted to hospital after a period of out-patient treatment. It seems possible that the influence of stress and life events had been discussed during this experience as psychiatric out-patients and they may have

incorporated this into their understanding of mental illness. Six of the 19 were admitted because of drinking problems and from their responses it seems that they considered alcohol abuse to be a reaction to stressful conditions.

Like the subjects in the preceding category, mental illness was seen to be caused by events which were largely uncontrollable and therefore they considered the individual to be blameless. However, in emphasising the importance of seeking help or removing oneself from the stressful situation, individuals were to some extent seen as responsible for preventing further deterioration.

(d) Subjects who Considered that Mental Illness is Caused by Events, Pressures or Situations which Affect Individuals Differently

Another 17 subjects cited social/environmental factors as the main cause of mental illness. These, however, are distinct from those discussed in the second and third categories in that they emphasised the idea that events, pressures or situations impact on individuals differently. Some were seen to be more vulnerable than others to the effects of these social/environmental factors and hence more susceptible to mental illness. In contrast to the subjects discussed in the second and third categories who considered that all individuals are equally susceptible to the effects of adverse events or situations, these subjects considered the individual's ability to cope as central in determining whether or not mental illness would occur. This view is expressed in the following quotation:

> There's various causes. Again it's stresses and strains - which is some of the people in here. Again it's just something that one person could cope with which another person couldn't. Another person could just take it in their stride. Which most people do of course when these things happen. They just manage to cope with it anyway. But another person again would just be put right inside some place, you know.

Although this perspective of mental illness introduces the idea of individual vulnerability or strength as an intervening variable between social/environmental factors and mental illness, this was defined by these subjects in terms of personality characteristics and not in sociological terms. The subjects giving this view also tended to include an element of blame (although this was not used in the same way as in category (f) where blame was seen to be the central feature). For example, one subject responded to the question of preventing mental illness in the following way:

> Some people say you're a victim of circumstances but I think you're not really. I think you're a victim of yourself. I think a lot of things can happen and there are ways you can have a choice, you've always a choice of a way to react to something.

Whereas susceptibility to physical illness (with some exceptions) would likely not be considered a matter of individual blame, susceptibility to mental illness appears here to involve some moral judgement. An element of failure was particularly expressed by the four parasuicides in this category.

When asked if mental illness could be 'cured', these subjects tended to be optimistic. None thought of it as hopeless. They did not tend to mention individual responsibility as an integral part of this.

Three of these subjects had had psychiatric out-patient treatment in the past and a further three were admitted after a period as out-patients. As with similar subjects in category (c), this experience may have influenced their ideas, for example in discussions of the importance of stress and life events.

(e) Subjects who Considered that Mental Illness Results from the Individual's own Psychological or Emotional Disposition

In contrast to the subjects discussed in the three preceding categories, all of whom emphasised the influence of external factors in the aetiology of mental illness, another large group of subjects stressed it as an internal process caused by the individual's emotional or psychological disposition. Twenty-four subjects described it in this way. These subjects appeared to be talking in terms of a personality type, although the idea of 'personality' was not particularly well developed. The type of individual whom they discussed, however, appears to be an anxious or nervous person who could bring mental illness upon themselves where there was no apparent external cause or trigger. The main examples of this, given by these subjects, were individuals who were unable or reluctant to discuss or disclose anxieties or who were generally preoccupied with an anxiety. Anxieties were considered to be based on what would be perceived by 'normal people' as minor and lacking a sense of proportion was thought to be the cause, not necessarily the symptom of mental illness. 'Nerves' as a cause was a major theme in this category. From their responses, this seems another way of expressing a similar emotional state. This view is seen in the following description of mental illness.

> Well mental illness to me would be caused by a lot of various things; worry for a start, about any subject, any subject you care to mention. And worry and worry and worry and it builds up and if they can't - I reckon about mental illness too, one cure for that could be something from just getting things off your chest, instead of bottling things up inside of you. And get things off their chest and confide in anybody. I imagine in a lot of cases its, they're making mountains out of molehills, creating problems which are non-existent.

The main characteristic of the description given by subjects in this category is the non-disclosure of an anxiety, preoccupation over a period of time and a failure to act.

These subjects described an increasing internal force which can be differentiated from an increase or an additive effect from external stresses on the individual, such as described by subjects in category (c). According to these descriptions, such non-disclosure or preoccupations are accompanied or followed by increased internal pressure and eventually some type of 'breakdown' or the eventual inability on the part of the individual to escape this pattern. The following illustrates this process:

> I think you can become mentally ill from keeping too much inside yourself. You can't talk about it. If you can't express your feelings, it's all building up inside, you know, all stays up inside.

The need for catharsis, then, seems to be a dominant theme among subjects in this research. It may be that they themselves found some relief from expressing their feelings to their psychiatrists and that this found expression in this view of mental illness. It is also possible that such a view is widely held in society generally -

including among those with no personal experience of psychiatric disorder.

Following from this view, the cathartic effect of disclosing anxieties was seen as the only way of preventing mental illness. Significant others were seen as possible resources for this and failing that, a GP or a psychiatrist. This view on the possibility of intervention was expressed as follows:

> You could go and see your GP and talk it over with a close friend or something like that and keep on discussing it and discussing it and bring it out in the open as often as possible and see if you can get rid of it, get rid of the idea in his mind. Failing that you go to see a psychiatrist and seek professional help.

In some instances these subjects' ideas on mental illness aetiology may have stemmed from their perspectives of their own situations prior to hospitalisation. Ten, for example, described the process leading to their admission as one in which they had not discussed their feelings with significant others. This may have been because of the same inability to disclose emotions emphasised in their views in the causes of mental illness. Six of the 24 were admitted after a suicide attempt and another six said they had been under pressure to admit themselves - all of which possibly indicates a feeling of failing to act, a failure to disclose anxieties prior to hospitalisation.

(f) Subjects who Considered that Mental Illness Results from a Deviant Lifestyle or Behaviour

The final major perspective emerging from these subjects' responses was that mental illness resulted from a deviant lifestyle or

behaviour. The individuals were considered to be culpable for this. Drinking or drug abuse were thought to be major contributing factors. Blame was the main characteristic of this theme which was given by 13 subjects as their perspective on the aetiology of mental illness.

One subject in discussing his own problem with drinking described this view as follows:

> Well it's completely up to his own self as far as I'm concerned. When I was 13 years old I was in the best kind of shape. Once I started working I just started knocking around with some of the wrong bunch and you're just drinking, drinking, drinking and all of a sudden you're hooked on the stuff and you're probably doing drugs, smoking dope, hash, whatever, and it all adds up after a while and before you're 22, 23 years old, and suddenly you need help.

This view on drinking contrasts with views discussed earlier where such problems were considered to be the result of adverse life circumstances. His response to the possibility of preventing mental illness, that individuals were not amenable to accepting advice from others, was typical of views in this category.

> Well it's something that a person, no one can tell you - and then it's up to the person himself really. If he wants to go that far, well, every night get drunk, get stoned at the same time, you're asking for trouble. This is going to end up.

Alcohol and drug abuse were not the only behaviours for which individuals were seen to be culpable. Other subjects, particularly in Newfoundland, mentioned not socialising enough or alternatively socialising too much. These were also seen as lifestyles for which the individual was responsible and which could result in mental illness.

A few subjects did suggest that individuals could make the decision to alter their behaviour or lifestyle and so prevent mental illness, if they recognised that it was potentially detrimental, although such recognition was thought to be unlikely. Some Newfoundland subjects said that mental illness could be prevented by socialising more, making sure one had a good number of friends or by generally keeping busy.

The subjects in this category, like most of the others in this research, tended to be optimistic about the treatment or 'cure' of mental illness.

Despite seeing individuals as culpable for their actions in causing mental illness, this did not necessarily translate into seeing themselves as taking responsibility in their own treatment. This will be discussed below in a consideration of how the subjects perceived their patient role.

In accordance with their views on aetiology, subjects appear to have been admitted to hospital because of their behaviour or 'lifestyle'. Only one of these 13 had been admitted because of depression or anxiety. Seven of the 13 had problems with drinking and another two appear to have been admitted because of disruptive behaviour. Eleven of these subjects were male, which partly reflects the predominance of males in the sample admitted because of drinking problems.

(g) Subjects with no Opinion on the Aetiology of Mental Illness

Eight subjects either had no opinion on the aetiology of mental illness or the information they gave was inadequate for them to be

included in the above categories. Four of these either thought they had no problem or had been admitted with what they perceived as a physical disorder. The others were suffering from depression. It seems likely that either these subjects did not think of themselves as mentally ill or their depressed condition was such that they could not clearly conceptualise their views on the causes of mental illness.

(h) 'Multi-category' Subjects

Ten subjects - five Edinburgh and five Newfoundland - emphasised equally two of the above perspectives. These, as was seen above, were not necessarily contradictory and in fact they were in some instances complementary. This was most notable among those who said that (a) mental illness was caused by physiological factors and (b) mental illness could be caused by an external event. Thus, these subjects stress that individuals had no responsibility and no control in either of these two situations.

It may be that these subjects forwarded two views of mental illness because they were unsure of their own condition or because they wished to deny that they were mentally ill. Some appeared to have been intent on denying individual responsibility for their own illness.

It is of course possible that these subjects were simply expressing alternative explanations on a topic on which there is no clear professional consensus anyway. The alternatives offered by some of these subjects may simply reflect a contrast between one perspective of mental illness which considers the importance of hereditary or congenital factors and a more recent emphasis on the influence of stress on illness.

The types of subject who subscribed to more than one view on the aetiology of mental illness will be considered below.

Subjects' Characteristics and Aetiological Themes

The subjects subscribing to each of the above categories were as follows:

TABLE 6:2 Subjects' Aetiological Themes

Aetiological Themes	Number of Subjects
(a)	16
(b)	13
(c)	19
(d)	17
(e)	24
(f)	13
no code	8
Total	110

(Total = 110. This includes ten 'multi-category' subjects, each coded twice.)

For statistical purposes, the 'multi-category' subjects may be taken as a distinct group. Of course this changes slightly the distribution of those subscribing to some of the categories. When these ten subjects are considered as a separate group the distribution is as follows:

TABLE 6:3 Subjects' Aetiological Themes

Aetiological Themes	Number of Subjects
(a)	8
(b)	8
(c)	17
(d)	16
(e)	22
(f)	11
multi-category	10
no code	8
Total	100

A distinguishing feature of the aetiological themes was that of individual blame or personal responsibility for the onset of mental illness. Categories (a), (b) and (c) did not attribute blame or responsibility to the individual, while (d), (e) and (f) did so. Comparisons will be made here both in terms of the individual categories and in terms of these two broad categories.

Given that the subjects in this research were not asked directly what they thought had caused their own illness, conclusions about the meaning of their adherence to a particular aetiological theme must remain tentative. It was not always apparent, as was seen in the above discussion, whether these subjects were drawing upon their understanding of the causes of their own conditions in expressing their views on the aetiology of mental illness, or if they were discussing an illness with which they did not identify their own illness. This partly relates to the use of the term 'mental illness' itself. Within each aetiological category were both those who thought of themselves as 'mentally ill' and those who denied that this label was applicable. This was apparent in their above descriptions

and when their descriptions of mental illness and the 'mentally ill' are compared with their opinions on aetiology. Subjects who used only negative stereotypes in their descriptions of the mentally ill, it was argued in Chapter 5, also denied that this label was appropriate to their own illness. Those who described mental illness as a neurotic disorder or as a wide range of conditions were apparently less concerned to deny this label. However, Table 6:4 shows how these three types of subject are distributed among the categories when these views are compared to those on aetiology.

The numbers in each cell are very small and so conclusions must be tentative. Subjects who thought that mental illness was caused by hereditary or congenital factors (a) were more likely to have described the mentally ill in terms of a negative stereotype - as unpredictable, non-understandable and perhaps as dangerous - than they were to have described mental illness as a neurotic disorder or as a wide range of conditions. Those who thought that mental illness resulted either from a particular life event or from the cumulative effect of stressful situations (b) or (c) were less likely to have used negative stereotypes only in describing the mentally ill. Stressful life events may be more understandable and therefore not likely to be seen as the cause of dangerous and unpredictable behaviour.

The distribution in the other categories is less clear. The exception to this are those identified as 'multi-category' subjects. Not surprisingly seven of the ten described mental illness as encompassing a wide range of conditions (Table 6:4). Thus they considered mental illness to have different causes and to have

different behavioural manifestations.

Of course some subjects were probably ambivalent about what they thought of mental illness in relation to themselves. Although they may have used their descriptions of mental illness to deny the mental illness label, they may also have described their attitudes to the causes of their own illness in discussing their general opinions on the aetiology of mental illness.

TABLE 6:4 Subjects' Aetiological Themes (all categories) by Conceptions of Mental Illness

Aetiological themes	Conceptions of Mental Illness: Stereotypes	Aggression/ anxiety	Both	Total
(a)	5 (17.9%)	3 (12.0%)	-	8
(b)	1 (3.6%)	1 (4.0%)	6 (16.7%)	8
(c)	3 (10.7%)	8 (32.0%)	6 (16.7%)	17
(d)	5 (17.9%)	4 (16.0%)	7 (19.4%)	16
(e)	7 (25.0%)	7 (28.0%)	7 (19.4%)	21
(f)	4 (14.3%)	2 (8.0%)	3 (8.3%)	9
multi-category	3 (10.7%)	-	7 (19.4%)	10
Total	28	25	36	89

(Totals are less than 100 because of those not coded on 'conceptions' and on 'aetiology')

The subjects in this research, it was argued, used their descriptions of mental illness and the mentally ill in different ways to deal with a potentially stigmatising identity. It might also have been expected that they would have expressed their opinions on the causes of mental illness so as to justify or rationalise their own situation. Some more than others might have been expected to have blamed themselves for becoming ill, while some might have been expected

to use the opportunity to negate such personal responsibility. However, when the types of subject who assigned individual blame are compared with those who did not, only a few patterns emerge (Table 6:5).

Those describing mental illness in terms of a negative stereotype only were more likely to assign individual blame (64%) than not to do so (36%) (Table 6:5). Again, this may be a reflection of those subjects' negative and perhaps condemning attitudes towards the 'mentally ill'. However, Table 6:5 also shows that a high proportion of subjects describing mental illness as depression and as a wide range of conditions (and therefore those who were likely to consider themselves as mentally ill) also apportioned such blame to the individual (52%).

TABLE 6:5 Subjects' Aetiological Themes (combined categories) by Conceptions of Mental Illness

Aetiological themes	Conceptions of Mental Illness Stereotypes	Aggression/ anxiety	Both	Total
No individual blame (a) (b) and (c)	9 (36.0%)	12 (48.0%)	12 (41.4%)	33
Individual blame (d) (e) and (f)	16 (64.0%)	13 (52.0%)	17 (58.6%)	46
Total	25	25	29	79

$x^2 = 0.742$, df = 2, n.s.

(Totals are less than 100 because those not coded on 'conceptions', on 'aetiology' and 'multi-category' subjects are not included.)

When the subjects in the two locations are compared some differences are apparent (Table 6:6). As was noted in the first section of this chapter, Edinburgh subjects were less likely than Newfoundland subjects to cite behavioural causes of mental illness. Not surprisingly this is reflected in the aetiological themes. Table 6:6 shows that Newfoundland subjects were more (18.2%) likely than Edinburgh subjects (6.3%) to consider that mental illness resulted from an individual's behaviour or lifestyle (category (f)). They were also more likely to consider that mental illness resulted from hereditary or congenital factors (15.9%). Edinburgh subjects more than Newfoundland subjects subscribed to categories (b), (c) and (d) - those themes which focussed on social/environmental influences in the aetiology of mental illness. The emphasis on social causes by Edinburgh subjects was also noted in the first section of this chapter.

TABLE 6:6 Subjects' Aetiological Themes (all categories) by Location

Aetiological themes	Location Edinburgh	Newfoundland	Total
(a)	1 (2.1%)	7 (15.9%)	8
(b)	6 (12.5%)	2 (4.4%)	8
(c)	11 (22.9%)	6 (13.6%)	17
(d)	12 (25.0%)	4 (9.1%)	16
(e)	10 (20.8%)	12 (27.3%)	22
(f)	3 (6.3%)	8 (18.2%)	11
multi-category	5 (10.4%)	5 (11.4%)	10
Total	48	44	92

(Totals are less than 100 in this and subsequent Tables (all categories) because of those not coded on 'aetiology)

When the categories are combined to examine those blaming the individual to some extent and those who did not, few cultural differences emerged (Table 6:7).

TABLE 6:7 Subjects' Aetiological Themes (combined categories) by Location

Aetiological themes	Location Edinburgh	Newfoundland	Total
No individual blame (a) (b) and (c)	18 (41.9%)	15 (38.5%)	33
Individual blame (d) (e) and (f)	25 (58.1%)	24 (61.5%)	49
Total	43	39	82

$x^2 = 0.096$, df = 1, n.s.

(Totals are less than 100 in this and subsequent Tables (combined categories) because those not coded on 'aetiology' and 'multi-category' subjects are not included)

Table 6:8 shows that a higher percentage of females subscribed to categories (d) and (e) - (22.9% and 31.4%) - that is they were more likely to say that mental illness resulted from events, pressures or situations which affect individuals differently or that it arises from the individual's own psychological or emotional disposition. It might have been expected that males more than females would have subscribed to category (e) if, as the literature suggests, males are less likely than females to disclose and report emotional problems. As was seen above, one of the main features of this theme was the individual's inability to disclose anxieties. However, it may be that this is a perspective that would be held by those suffering from depression, and a greater proportion of female subjects had been admitted to hospital because of this condition.

Males (15.8%) more than females (5.7%) described the causes of mental illness in terms of a deviant lifestyle or behaviour - (f) - (Table 6:8). If, as was suggested above, these particular subjects were in fact drawing from their own experience in expressing their views on the causes of mental illness then this likely reflects the predominance of males in the sample admitted because of drinking problems.

TABLE 6:8 Subjects' Aetiological Themes (all categories) by Sexual Status

Aetiological themes	Sexual Status Female	Male	Total
(a)	3 (8.6%)	5 (8.8%)	8
(b)	3 (8.6%)	5 (8.8%)	8
(c)	6 (17.1%)	11 (19.3%)	17
(d)	8 (22.9%)	8 (14.0%)	16
(e)	11 (31.4%)	11 (19.3%)	22
(f)	2 (5.7%)	9 (15.8%)	11
multi-category	2 (5.7%)	8 (14.0%)	10
Total	36	57	92

When the combined categories are considered, however, few differences emerge (Table 6:9). Females (63.6%) more than males (57.1%) appear slightly more likely to attach blame to the individual.

TABLE 6:9 Subjects' Aetiological Themes (combined categories) by Sexual Status

Aetiological themes	Sexual Status Female	Male	Total
No individual blame (a) (b) and (c)	12 (36.4%)	21 (42.9%)	33
Individual blame (d) (e) and (f)	21 (63.6%)	28 (57.1%)	49
Total	33	49	82

$x^2 = 0.295$, df = 1, n.s.

There were only small differences between married and unmarried subjects, both when all the categories (Table 6:10) and when the combined categories (Table 6:11) are considered.

TABLE 6:10 Subjects' Aetiological Themes (all categories) by Marital Status

Aetiological themes	Marital Status Unmarried	Married	Total
(a)	4 (7.5%)	4 (10.3%)	8
(b)	4 (7.5%)	4 (10.3%)	8
(c)	11 (20.8%)	6 (15.4%)	17
(d)	10 (18.9%)	6 (15.4%)	16
(e)	11 (20.8%)	11 (28.2%)	22
(f)	7 (13.2%)	4 (10.3%)	11
multi-category	6 (11.3%)	4 (10.3%)	10
Total	53	39	92

TABLE 6:11 Subjects' Aetiological Themes (combined categories) by Marital Status

Aetiological themes	Marital Status Unmarried	Married	Total
No individual blame (a) (b) and (c)	19 (40.4%)	14 (40.0%)	33
Individual blame (d) (e) and (f)	28 (59.6%)	21 (60.0%)	49
Total	47	35	82

$x^2 = 0.0014$, df = 1, n.s.

Although the numbers are very small, it appears that those with under nine years of schooling were more likely than those with university or college education to subscribe to categories (a), (c) and (e). That is they were more likely to say that mental illness was caused by hereditary or congenital factors (13.3%); resulted from the cumulative effect of stressful situations (26.7%) and arose

from the individual's psychological or emotional disposition (33.3%) (Table 6:12). Table 6:12 also shows that those with university or college education were most likely to subscribe to (d) - (24.0%) - to think of mental illness as the result of events or situations which affect individuals differently. This may reflect a more subtle understanding of psychiatric theory and the nature of mental illness. It also seems that a higher proportion of the multi-category subjects had had some university or college education (Table 6:12).

TABLE 6:12 Subjects' Aetiological Themes (all categories) by Education Level

Aetiological themes	Education Level 0-9 years	10-13 years	University/ college	Total
(a)	4 (13.3%)	3 (8.1%)	1 (4.0%)	8
(b)	1 (3.3%)	4 (10.8%)	3 (12.0%)	8
(c)	8 (26.7%)	5 (13.5%)	4 (16.0%)	17
(d)	3 (10.0%)	7 (18.9%)	6 (24.0%)	16
(e)	10 (33.3%)	10 (27.0%)	2 (8.0%)	22
(f)	4 (13.3%)	4 (10.8%)	3 (12.0%)	11
multi-category	-	4 (10.8%)	6 (24.0%)	10
Total	30	37	25	92

Few differences emerged when blame and individual responsibility were considered in relation to education level (Table 6:13).

TABLE 6:13 Subjects' Aetiological Themes (combined categories) by Education Level

Aetiological themes	Education Level 0-9 years	10-13 years	University/ college	Total
No individual blame (a) (b) and (c)	13 (43.3%)	12 (36.4%)	8 (42.1%)	33
Individual blame (d) (e) and (f)	17 (56.6%)	21 (63.6%)	11 (57.9%)	49
Total	30	33	19	82

$x^2 = 0.353$, df = 2, n.s.

There were only small differences when the age of the subjects subscribing to each of the themes is considered. These distributions are shown in Tables 6:14 and 6:15.

TABLE 6:14 Subjects' Aetiological Themes (all categories) by Age

Aetiological themes	Age Under 30	30-44 years	45 and over	Total
(a)	3 (8.3%)	3 (10.0%)	2 (7.7%)	8
(b)	4 (11.1%)	4 (13.3%)	-	8
(c)	6 (16.7%)	5 (16.7%)	6 (23.1%)	17
(d)	5 (13.9%)	7 (23.3%)	4 (15.4%)	16
(e)	10 (27.8%)	5 (16.7%)	7 (27.0%)	22
(f)	5 (13.9%)	3 (10.0%)	3 (11.5%)	11
multi-category	3 (8.3%)	3 (10.0%)	4 (15.4%)	10
Total	36	30	26	92

TABLE 6:15 Subjects' Aetiological Themes (combined categories) by Age

Aetiological themes	Age Under 30	30-44 years	45 and over	Total
No individual blame (a) (b) and (c)	13 (39.4%)	12 (44.4%)	8 (36.4%)	33
Individual blame (d) (e) and (f)	20 (60.6%)	15 (55.6%)	14 (63.6%)	49
Total	33	27	22	82

$x^2 = 0.345$, df = 2, n.s.

There was very little difference when experience of psychiatry is considered (Tables 6:16 and 6:17).

TABLE 6:16 Subjects' Aetiological Themes (all categories) by Experience of Psychiatry

Aetiological themes	Experience of Psychiatry Low	High	Total
(a)	3 (6.8%)	5 (10.4%)	8
(b)	4 (9.1%)	4 (8.3%)	8
(c)	8 (18.2%)	9 (18.8%)	17
(d)	7 (15.9%)	9 (18.8%)	16
(e)	11 (25.0%)	11 (22.9%)	22
(f)	5 (11.4%)	6 (12.5%)	11
multi-category	6 (13.6%)	4 (8.3%)	10
Total	44	48	92

TABLE 6:17 Subjects' Aetiological Themes (combined categories) by Experience of Psychiatry

Aetiological themes	Experience of Psychiatry Low	High	Total
No individual blame (a) (b) and (c)	15 (39.5%)	18 (40.9%)	33
Individual blame (d) (e) and (f)	23 (60.5%)	26 (59.1%)	49
Total	38	44	82

$x^2 = 0.018$, df = 1, n.s.

As can be seen in Table 6:18, manual workers were more likely than non-manual workers to subscribe to categories (a) and (f) - that is they thought of mental illness as resulting from congenital or hereditary factors or because of a deviant lifestyle or behaviour. The latter was described more by male than female subjects and the differences here probably partly reflect the greater proportion of male to female manual workers. A higher percentage of non-manual compared to manual workers either described mental illness as the result of different individual responses to stressful situations (d) or were 'multi-category' subjects (Table 6:18). This is similar to the pattern for education level. This similarity is not surprising given the relationship between education and occupational status (and also that in this research the occupational status of those never employed was based on number of years of education).

TABLE 6:18 Subjects' Aetiological Themes (all categories) by Occupational Status

Aetiological themes	Occupational Status Non-manual	Manual	Total
(a)	1 (2.6%)	7 (13.2%)	8
(b)	3 (7.7%)	5 (9.4%)	8
(c)	7 (17.9%)	10 (18.9%)	17
(d)	10 (25.6%)	6 (11.3%)	16
(e)	9 (23.1%)	13 (24.5%)	22
(f)	3 (7.7%)	8 (15.1%)	11
multi-category	6 (15.4%)	4 (7.5%)	10
Total	39	53	92

The combined categories show little difference in the way non-manual and manual workers thought of mental illness aetiology (Table 6:19). A slightly higher proportion of non-manual workers (66.6%) than manual workers (55.1%) blamed the individual for causing his or her illness.

TABLE 6:19 Subjects' Aetiological Themes (combined categories) by Occupational Status

Aetiological themes	Occupational Status Non-manual	Manual	Total
No individual blame (a) (b) and (c)	11 (33.3%)	22 (44.9%)	33
Individual blame (d) (e) and (f)	22 (66.6%)	27 (55.1%)	49
Total	33	49	82

$x^2 = 1.096$, df = 1, n.s.

It might have been expected that those not employed would have been more likely to think of mental illness as the result of life events or social pressures (and thus to subscribe to (b), (c) and (d)) - particularly as several subjects described job loss or financial problems as factors contributing to mental illness. However, as can be seen in Table 6:20, those in employment were equally likely to subscribe to these categories. A higher percentage of those in employment (31.9%) than those not in employment (15.6%) described mental illness as a result of the individual's emotional or psychological disposition (e) (Table 6:20). This is reflected in the slightly greater percentage of these same subjects who assigned blame to individuals for causing their own illness (Table 6:21).

TABLE 6:20 Subjects' Aetiological Themes (all categories) by Employment Status

Aetiological themes	Employment Status: Employed	Not Employed	Total
(a)	3 (6.4%)	5 (11.1%)	8
(b)	4 (8.5%)	4 (8.9%)	8
(c)	9 (19.1%)	8 (17.8%)	17
(d)	7 (14.9%)	9 (20.0%)	16
(e)	15 (31.9%)	7 (15.6%)	22
(f)	4 (8.5%)	7 (15.6%)	11
multi-category	5 (10.6%)	5 (11.1%)	10
Total	47	45	92

TABLE 6:21 Subjects' Aetiological Themes (combined categories) by Employment Status

Aetiological themes	Employment Status: Employed	Not Employed	Total
No individual blame (a) (b) and (c)	16 (37.2%)	17 (43.6%)	33
Individual blame (d) (e) and (f)	27 (62.8%)	22 (56.4%)	49
Total	43	39	82

$x^2 = 0.346$, df = 1, n.s.

A confounding factor in this chapter has been that some subjects clearly drew upon their beliefs about the causes of their own illness in discussing the aetiology of mental illness while others did not. Conclusions, therefore, about the meaning of their adherence to particular aetiological themes must be made with this in view.

Some of these individual themes were subscribed to more by some subjects than by others. Category (a) - that mental illness was the result of hereditary or congenital factors - was advanced more by manual than non-manual workers, as was (f) - that mental illness was caused by a deviant lifestyle or behaviour. The latter was also described more by males than by females. This may have been partly a result of the higher proportion of males with drinking problems. Female subjects, those with university or college education, and non-manual workers, more frequently subscribed to (d) - mental illness as a result of different individual responses to stressful situations - than did males, those with less than college education

and manual workers. Females more than males and those in employment were also more likely to subscribe to (e) - mental illness as a result of the individual's emotional disposition. This, it was argued, was partly because of the higher proportion of females suffering from depression. Edinburgh subjects were more likely than Newfoundland subjects to subscribe to (b), (c) and (d) - those themes which emphasised somewhat the importance of social/environmental factors in the aetiology of mental illness. This reflects the findings in the first section of this chapter.

Subjects, discussed in Chapter 5, who described the mentally ill in terms of unpredictable, non-understandable and perhaps dangerous behaviour - those using negative stereotypes only - also less frequently subscribed to categories (b) and (c) (mental illness as the result of the impact of an external event or of the cumulative effect of stressful situations). This may reflect the idea that stressful situations are understandable to most people and hence incompatible as causes of a non-understandable condition. The pattern also partly reflects the findings that fewer Edinburgh than Newfoundland subjects described the mentally ill in terms of a negative stereotype only.

Finally, a large percentage of the 'multi-category' subjects were found to be those with university or college education and who tended to describe mental illness as a wide range of conditions. This may reflect an 'informed' and 'educated' view of mental illness and/or, as was discussed in the last chapter, a wish to appear to hold such a view.

A central distinguishing feature of these categories was the

attribution of individual responsibility or blame in the aetiology of mental illness. Three of the categories included an element of such blame and three did not. These two broad categories were considered here.

It was thought that there might be a relationship between different ways of conceptualising mental illness and the attribution of individual blame. However, little emerged from this. Those who described the mentally ill in terms of a negative stereotype only were slightly more likely than others to assign such blame.

Females, non-manual workers and those currently in employment were also slightly more likely to attribute blame or responsibility to individuals than were males, manual workers and those not in employment. These differences, however, were very small.

Conclusion

This chapter has considered these subjects' views on the aetiology of mental illness - on the factors contributing to the illness and the possibilities of intervention and on outcome. As the literature on attitudes to mental illness suggests, a large proportion of these subjects thought in terms of social/environmental factors contributing to mental illness. Edinburgh subjects were more likely than Newfoundland subjects to express their views in these terms. Newfoundland subjects were also likely to cite physiological, psychological and behavioural factors.

Some subjects more than others subscribed to different themes. Of particular interest is that females more than males thought of mental illness as the result of the individual's emotional or

psychological disposition. Males more than females thought of mental illness as the result of an individual's deviant behaviour. This, it was argued, reflects the subject's own diagnoses and probably their perspectives on the causes of their own conditions.

The small group of 'multi-category' subjects who had a higher than average education level, tended to be among those in Chapter 5 who described mental illness as a wide range of conditions. Thus, in giving more than one view on the causes of mental illness and more than one perspective on the nature of mental illness, they advanced what appears to approach an 'informed' and 'educated' perspective of psychiatric illness.

It was argued in Chapter 5 that the subjects in this research used descriptions of mental illness and the mentally ill to deal in different ways with the potentially stigmatising label of mental illness. It might also have been expected that they would have dealt similarly with this problem in discussing aetiology and that different ways of attributing or negating individual blame would have been related to different responses to the label of mental illness and to other variables. However, little emerged when this factor was considered. Those who described the mentally ill in terms of a negative stereotype only were slightly more likely than others to attribute blame to the individual for causing his or her illness. Females, non-manual workers, and those currently in employment were also marginally more likely to assign such blame.

Whether these findings support or refute a labelling perspective is not clear. It might have been expected that those with fewest resources would have been least likely to assign blame to the

individual - thus seeing him or her as powerless in the process of becoming ill. Alternatively, assigning such blame may reflect a negative and condemning attitude towards the mentally ill and consistent with the findings in the last chapter it might have been expected that those with fewest resources would have been most likely to assign blame. However neither pattern was found here.

Finally that mental illness is thought of negatively is not supported by the general expression of optimism regarding recovery and 'cure' among these subjects. Of course this also reflects optimism or hope about their own situations.

CHAPTER 7

The Route to the Psychiatric Hospital and the Admission Process

This chapter considers the patterns of referral and the route to the psychiatric hospital for the 100 first admission subjects in this research (50 to the Royal Edinburgh Hospital and 50 to Waterford Hospital and the Health Sciences Centre Psychiatric Unit, St John's). It also addresses the question of how these 100 first admission subjects perceived the processes leading to their admission.

The topics included in the interviews were: the admission itself and the processes leading up to it; who made the psychiatric referral; the perceived problem or illness and how serious it was considered to be; who was involved in decisions and what kind of help or advice had been received; how the subjects felt about the admission and if they had discussed this with anyone, and who made the decision regarding the admission.

The subjects in this research may have consulted GPs or family doctors for similar problems in the past and they may even have been referred for psychiatric out-patient treatment, but this was the first time that they had been admitted to hospital as psychiatric in-patients. As such, their perceptions of the route to the psychiatric hospital are of interest in terms of contributing to the 'debate' between the labelling or societal reaction theorists and those defending a medical model. To this end, certain questions are of interest. Had these subjects themselves thought that they had a problem in need of medical attention? Did they think that other people had played a major part in defining their behaviour or

emotions as problematic and indeed in deciding the route to the psychiatric admission? Did they feel that they themselves had played an active part in the process? Had they felt coerced into obtaining medical attention or into the admission itself?

Patterns of Referral and Admission

The processes by which the subjects in this research reached a psychiatric admission are largely consistent with Goldberg and Huxley's (1980) model and although the psychiatric referral pattern and the admission processes in the two areas - Edinburgh and Newfoundland - differed to some extent, as a whole they shared common features.

These subjects followed a variety of routes before being admitted to psychiatric facilities, with a large proportion being referred by their GPs or family doctors after the subjects had consulted them regarding their problems. Several, however, were admitted after a period as psychiatric out-patients. The subjects in Edinburgh had as a whole been attending on an out-patient basis for a shorter period of time than similar subjects in Newfoundland. Some subjects arrived at the psychiatric facilities with no referral. (1) Other subjects were referred by doctors other than psychiatrists and a significant number

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(1) This is an unusual occurrence in the UK but it is not impossible for a person to arrive requesting treatment or after having been taken directly to the hospital by family or friends and to be seen by a psychiatrist in the out-patient clinic. Thus several of the filters described by Goldberg and Huxley (1980) are bypassed. It would be possible for such an individual to be admitted at this point if the psychiatrist thought that immediate attention was indicated

of subjects were admitted to hospital after suicide attempts. All of these subjects were admitted on a voluntary or informal basis with the exception of six involuntary admissions in Newfoundland and one compulsory admission to the Royal Edinburgh Hospital.

Of the 50 admissions to the Royal Edinburgh Hospital, 29 were referred by their GPs specifically to a psychiatrist. Twenty three of these were referred directly by their GPs to the Royal Edinburgh Hospital; two were admitted directly to the ward - their admission pre-arranged - and 16 were seen by a psychiatrist at the out-patient clinic and admitted immediately or as soon as a bed became available. However, two of these 16 were first seen by a psychiatrist at the University Health Centre and another two were first seen by a psychiatrist at home. Another five of the 23 were seen at the out-patient clinic on more than one occasion before they requested an admission or it was suggested by a psychiatrist. Of these five, one attended as a psychiatric out-patient before the admission.

The other six of the 29 'GP psychiatric referrals' were referred first to another psychiatric facility (at the Western General Hospital or at Sighthill Health Centre) where they were seen by a psychiatrist before being referred to the Royal Edinburgh Hospital. One of these received psychiatric treatment on an out-patient basis before this referral was made.

Three subjects were referred initially by their GPs to general hospitals and were referred after seeing a psychiatrist to the Royal Edinburgh Hospital. Two subjects arrived at the hospital with no referral, one having gone on his own initiative and the other having been taken by his friends. Another subject contacted the Royal

Edinburgh Hospital initially herself and was referred to the Western General Hospital where she was seen before her admission. Two other subjects were referred by psychiatrists from elsewhere in the country. The remaining 13 were 'parasuicides', 12 of whom were referred from the Royal Infirmary of Edinburgh and one from Leith Hospital. One of these 13 had been receiving out-patient treatment during the previous year (Table 7:1).

TABLE 7:1 Admissions to Royal Edinburgh Hospital

GP REFERRALS TO PSYCHIATRY

GP Referrals to Royal Edinburgh Hospital

seen at out-patients and admitted	12			
seen at out-patients on more than one occasion and admitted	4			
admitted after out-patient treatment	1			
admitted directly to ward	2			
admitted after consultation with psychiatrist at home	2			
admitted after consultation with psychiatrist at University Health Centre	2	23		

GP referrals to Other Psychiatric Facility

followed by referral to REH out-patients and admitted	5			
referred after out-patient treatment to REH and admitted	1	6	29	
INITIAL GP REFERRALS TO GENERAL MEDICAL FACILITIES FOLLOWED BY REFERRAL TO REH			3	
REFERRED BY PSYCHIATRISTS ELSEWHERE AND ADMITTED			2	
SELF REFERRAL TO OTHER PSYCHIATRIC FACILITY FOLLOWED BY REFERRAL TO REH			1	
NO REFERRAL				
went by self to hospital		1		
taken by friends to hospital		1	2	37
PARASUICIDES				
admitted to RIE and transferred to REH (1 receiving out-patient treatment at the time)		12		
admitted to Leith Hospital and transferred to REH		1		13
				50

Of the 50 Newfoundland subjects, 17 were referred by a family doctor to a psychiatrist. Sixteen were referred initially either to the General Hospital Health Sciences Centre or to Waterford Hospital. The other was referred first to another psychiatric facility and this was followed by a referral to a medical ward at the Health Sciences Centre and then by a transfer to the psychiatric unit. Eight of the 'family doctor psychiatric referrals' - including one who had also attempted suicide before she consulted her doctor - were seen at the out-patient clinic or at the admissions office and admitted directly or when a bed became available. Another three were seen at the out-patient clinic on more than one occasion before an admission was recommended. Another four were admitted directly to the ward, their admission having been pre-arranged. One of these four was consulting a psychiatrist on an out-patient basis at the time. Another of the four had initially referred herself to another general hospital before her family doctor arranged her transfer.

Two of the 50 subjects were referred initially by their family doctor to a medical ward and then transferred to the Health Sciences Centre Psychiatric Unit. Ten were admitted with no referral at all, two of these being self-referrals. Of these ten, another was taken to the Health Sciences Centre by a doctor from another hospital where she herself was employed. The other eight of the ten involved family or friends in anything from agreeing with the individuals that they needed treatment and accompanying them to the hospital, to actually taking the individuals there against their will.

In addition to those instances where the police were involved in the admission of parasuicides, they actively participated in six

admissions. One of these was actually referred by his family doctor.

Ten subjects were parasuicides but one of these ten was also a 'family doctor psychiatric referral'. Another was consulting a psychiatrist on an out-patient basis at the time. This case also involved the police in the admission.

The remaining seven of the 50 were admitted by the psychiatrist whom they were consulting on an out-patient basis (Table 7:2).

TABLE 7:2 Admissions to Health Sciences Psychiatric Unit and to Waterford Hospital, St John's, Newfoundland

FAMILY DOCTOR REFERRALS TO PSYCHIATRY				
Family Doctor Referrals to Health Sciences or Waterford				
seen at out-patients and admitted	7			
seen at out-patients on more than one occasion and admitted	3			
admitted directly to ward	3			
brought by police and admitted	1			
admitted after out-patient treatment	1	15		
Family Doctor Referrals to Other Psychiatric Facility				
followed by referral to medical ward then transfer to HS Psychiatric Unit		1	16	
INITIAL FAMILY DOCTOR REFERRALS TO GENERAL MEDICAL FACILITIES			2	
TAKEN BY POLICE TO HOSPITAL AND ADMITTED			5	
NO REFERRAL				
went by self to hospital		2		
taken by family/friends to hospital		7		
taken by other doctor to hospital		1	10	
ADMITTED BY PSYCHIATRIST AFTER OUT-PATIENT TREATMENT			7	40
PARASUICIDES				
family doctor referral to out-patients and admitted			1	
taken by police to Waterford and admitted (1 receiving out-patient treatment at the time)			2	
taken by family/friends to Waterford and admitted			2	
taken by family/friends to HS emergency and transferred to Psychiatric Unit			3	
transferred from other hospital			2	10
				50

A large proportion of subjects, then, in both Edinburgh and Newfoundland, were referred to a psychiatric facility by their GPs or family doctors. This is consistent with the literature which tends to agree on the crucial role played by the GP.

Of course only a small proportion of people suffering from psychiatric disorder are referred to specialist services and GPs themselves treat a considerable amount of psychiatric disorder in the community. In addition it is generally agreed that a great deal of disorder remains undetected (cf. Goldberg and Huxley, 1980). A detailed discussion of prevalence or of the treatment of disorder in the community is beyond the scope of this research. However, it must be noted that the subjects in this research represent only those who are referred through they system.

In addition, the literature has generally found that family doctors are not only important in terms of appropriateness, but also because of their accessibility - a factor which is crucial for those consulting on the NHS in Britain and in Canada through Government-run health insurance schemes.

Some subjects, however, did not pass through all the filters described by Goldberg and Huxley (1980). Those in both Edinburgh and Newfoundland going directly to the hospital or being taken there by family or friends appear to have bypassed the primary care stages and to have gone directly from the 'community' to a psychiatric service. Some of the parasuicides, as will be discussed in greater detail below, followed a similar pattern.

The referral pattern itself, however, does not give a clear picture of just how these subjects came to arrive at the psychiatric

hospital. Had they been active in recognising that they had a problem and in seeking help for it, or did they feel that other people had labelled the problem as indicative of mental illness and had acted to exclude them from the community? Had GPs largely performed not only the management but also the detection of psychiatric disorders on the route to the psychiatric hospital, as Goldberg and Huxley (1980) stress? This must be considered in greater detail in order to investigate what becoming a psychiatric patient meant to these subjects.

Problem Recognition and the Route to the Psychiatric Hospital

Significant others, GPs, family doctors, other members of the medical profession and psychiatrists all contributed in some way to the process leading to these subjects' admissions to psychiatric facilities. In some instances, the subjects themselves, without consulting significant others, identified their problems as specifically requiring psychiatric help and then obtained it. However, for most subjects the process leading to their admission was more complex. These subjects were concerned that their problems in some way incapacitated them in the performance of their social roles as employees, spouses, parents or friends. Some identified their problem as 'depression' or 'nerves' or 'drinking'. Some subjects were less specific about the nature of their problems and were generally anxious that something was wrong with them because they felt different from what they perceived as normal for themselves. Some felt that they had a problem but could not conceptualise why this had caused concern.

Not all of the subjects in the sample had considered that they had a problem. In some cases significant others had identified their behaviour as problematic and played an active part in getting the subject to hospital. In other cases the subject was consulting a GP or some other member of the medical profession who played a major role in identifying a problem as in need of psychiatric treatment. And in a few cases the police played this role. However, a considerable proportion of the sample said that they themselves had recognised that their problems required medical attention or even psychiatric treatment, although this was frequently after consultation with significant others. This recognition was not always reached in a simple way and negotiations for many went through several stages before the individual became a psychiatric patient.

Of course significant others may have been involved to a greater extent than was actually reported by the subjects and different people involved in each situation may not have agreed with each other as to the individual's condition or the most appropriate action to take. However, the pattern of events and the involvement of others as reported by the individual subjects reflect their subjective perceptions of the process leading to the psychiatric admission. Accordingly, each case followed one of seven basic processes:

(a) Subjects who said they had considered that they had a problem, whose subjective perception of the process leading to the admission was that they had been self-motivated in seeking help and that they had actively participated in decisions taken

(b) Subjects who said they had considered that they had a problem but who felt they had only been motivated to seek help after direct or indirect pressure from other people. In retrospect, however, their subjective impression was that they had felt in

control over the help seeking process and had actively participated in decisions taken in the process leading to the admission

(c) Subjects who said they had considered that they had a problem but whose subjective impression was that although they had initially been motivated to seek help in retrospect they felt a lack of control when it came to decisions taken in the process leading to the admission

(d) Subjects who said they had considered that they had a problem but who had avoided seeking help or refused to seek help. Their subjective impression of the process leading to the admission was that they had been compelled by actions taken by significant others or agencies and that they had not participated in decisions taken

(e) Subjects who said they had not considered that they had a problem and who therefore had not been motivated to seek help. Their subjective impression of the process leading to the admission was that they had been compelled by actions taken by significant others or agencies and that they had not participated in decisions taken.

The dynamics of problem recognition in relation to the admission process are thought to be somewhat different for those subjects admitted after receiving psychiatric out-patient treatment for some time and those admitted after a suicide attempt. Because of this, these subjects are not considered in the above categories but are discussed separately as follows:

(f) Subjects admitted after receiving out-patient treatment

(g) Parasuicides.

(a) <u>Subjects Motivated to Seek Help and who Actively Participated in the Process Leading to the Psychiatric Admission</u>

A considerable proportion of the subjects in this research described the process leading to their admission as one in which they

had been not only self-motivated to seek help, but also where they had actively participated in decisions leading to the hospital admission. They all said they had considered that they had a problem, although they had not necessarily conceptualised it in psychiatric terms, and they had wanted help for this problem. Ten of the 19 cases in this category were characterised by an agreement, or a consultation between the individual and significant others resulting in an agreement, that the individual had a problem and that medical help was needed.

For example, one male Newfoundland subject said that he had become depressed and started to drink heavily after the death of his elderly mother of whom he had been taking care. This death was one week before he was admitted to the Health Sciences Psychiatric Unit. This subject said that he had been concerned about his own behaviour and that he had wanted medical help.

> I figured it was about time to try and do something to help myself. So I went in to see the family doctor and he arranged to come in here.

He said that he had consulted his siblings who had arrived in Newfoundland for the funeral and they had encouraged him to consult his family doctor.

> A sister, she came home to the funeral from Virginia Beach and another brother from Montreal said probably the best thing you could do is to go up and see the doctor and see what he's got to say. Well I had that in my own mind. I didn't hesitate on this, I just went out.

There is little evidence that these subjects would not have pursued help even if significant others had not been involved. It was

the individuals themselves who generally initiated the help seeking process and significant others were supportive or encouraging. They are thus considered to be similar to the other nine who described the process leading to the admission as one in which they had been actively seeking help without having consulted significant others previously. Some of these had sought advice from their GP or family doctor, others had contacted psychiatric facilities directly. For these nine any discussion with significant others about a psychiatric admission was after the decision regarding such an admission had been made. It seems from some of these subjects' responses that they felt their family members or friends would not have been supportive of a psychiatric referral. One Edinburgh subject said:

> And I said (to her sister) 'I'm being admitted on Monday'. And she looked at me and she said, 'But you're not that bad, are you?' And I said that I felt for a while that I'm getting worse. So I would rather get into the hospital and that way get a clean break. And I think she felt a bit upset about it. But she sort of accepted it. And then I phoned home to say to my Mum and I told her and I think she was a bit dubious about it. But once I saw her the next day and explained it was for the best that I went away, she was OK.

In all 19 cases the individuals seem to have been actively seeking help for a problem which they themselves perceived as serious and which had been adversely affecting their lives in some way. The problems which they had been concerned with were not obviously different from those of the other subjects in this research. Most were concerned about an emotional problem which they perceived as deteriorating or simply not improving. They did not generally indicate why at that point they had decided that the problem was

serious enough to warrant seeking help or what made them decide that they could no longer tolerate a particular condition. For two subjects this was indicated to them by specific incidents - in one case by a 'blackout' and in another by an overdose of drugs two weeks previously. Another felt incapable of taking on a new job.

Six of these 19 subjects made the initial contact with the psychiatric facility themselves, and had themselves or in consultation with significant others defined their problems as psychiatric. The remainder, however, consulted their GPs or their family doctors who referred them to the psychiatric out-patient department at the hospital where an admission was suggested by the psychiatrist consulted. These subjects had defined their problems as medical, although not necessarily as psychiatric. In most of these instances the GP performed the function discussed above, of both identifying and managing psychiatric disorders. These subjects, however, appear to have been willing to be referred to psychiatry and did not feel that such a treatment option had been imposed on them. All of these 19 subjects expressed some relief regarding their admission to hospital.

These subjects tended to regard a psychiatric admission, not as a failure to cope, but as another resource which might help them. This is seen in the following statement.

> I was wanting to get something done about it. I wanted some treatment, not just tests. It was treatment I was more interested in, because all the tests have been done, you see. So by coming in here I might get this done within a fortnight or three weeks. Whereas if I was an out-patient they would say, 'Come back in a fortnight's time and see the doctor' and then, 'Come back in another fortnight'. So it's going to take more time. So the quicker I'm in - not the longer - but the quicker I was in here. I'm on the spot and get it done and get out.

Of course these subjects may have consulted significant others more than they actually expressed and indeed significant others or family doctors may have done more than just encourage help seeking. Negotiations may have been complex. It is even possible that significant others actually identified the problem as requiring help and treatment, in effect labelling or starting the process of labelling the individuals as 'mentally ill'. The subjects may have internalised this definition. Because of the nature of this research this process, from the perspective of significant others, is not known. What is known is that by the time they became psychiatric patients, these 19 subjects perceived the process which had led to their admission as one in which they had actively been seeking help, in which they had been self-motivated and in which they had actively participated in decisions at each stage.

These perspectives of course may also reflect more general positive attitudes towards psychiatry and a greater awareness or knowledge of emotional problems and their treatment.

Four of the 19 in this category had had psychiatric out-patient treatment at some time in the past. It may be that such experience could contribute to the future recognition of psychiatric problems. In these instances it also seems to have influenced an active and positive attitude towards help seeking.

(b) <u>Subjects who Actively Participated in the Process of the Psychiatric Admission but who had been Motivated to Seek Help only after Pressure from Others</u>

These 11 subjects are similar to those just discussed in that they described themselves essentially as help seekers and considered that

they had actively participated in the decisions at various stages leading to their admission. They said that they had realised they had a problem, but unlike those in the first category, they had not been self-motivated to seek help. Help was sought after significant others had directly or indirectly placed some pressure on them. In some instances this was perceived as increasing pressure.

These cases were characterised by subjects denying the seriousness of their problems, or attempting to deal with the problem by themselves. Significant others had generally encouraged the individuals to seek help or to continue seeking help but this had been ignored or opposed. These subjects described the process leading to their admission as one in which they eventually decided that their problems were becoming more serious and where they accepted increasing pressure from significant others. These cases were characterised by crises immediately prior to help seeking, such as arguments with spouses, or even physical confrontation, job loss or 'blackouts' - which indicated to these subjects that help was required.

In contrast to category (a), there was an element of a feeling of failure associated with the admission of needing help. However, all of these subjects expressed relief about eventually receiving psychiatric attention and even relief regarding their admission.

Three of these eleven initially contacted the hospital without consulting a family doctor. The remainder consulted their family doctors and described the consultation as one in which they admitted to needing help or in which they agreed to a psychiatric referral which had been suggested at an earlier time. (The GPs or family doctors may have been important in deciding that a problem was

psychiatric, but significant others also appear to have played a part in this.)

An example of this was a male subject in Edinburgh who had problems with drinking for which he had consulted his GP about one year prior to his admission. He was referred to the Royal Edinburgh Hospital and was seen there but not admitted. He said he had returned home and told his wife that there were no beds available. At this point his wife had thought his problems more serious than he did and she had wanted him to admit himself to hospital. She had continued to pressurise him to seek help throughout the year, but he had refused to do so. He said he realised that his problem was serious when he lost his job - this was one week before his admission. He had also been told by his doctor that he was endangering his health. The combination of all these factors seems to have motivated him into seeking further help.

> Just over the months, my wife of course, started to argue with me. 'You have to do something, you have to do something'. But they were always talking at the wrong time, when I was a bag of nerves and they weren't getting through to me. They were just making me angry and nervous - sort of stupid. I knew I had to do something about it. Because my doctor - no' the last one but the one a week ago - he says if you keep on going the way you're going, you've got four year. And that's no good because I've got three sons.

This subject returned to his GP who referred him to the Royal Edinburgh Hospital the following day and he was admitted to hospital.

Eight of these 11 subjects had drinking problems and a ninth was a heroin addict. There were only two of these subjects suffering from depression alone. It would seem that the nature of the problem which

the individual has affects the extent to which it is possible to delay and avoid seeking help. It is probably easier to rationalise drinking behaviour than an emotional disorder, as well as to convince both oneself and others that the problem can be dealt with without professional help.

For example, another male Edinburgh subject had been referred by his GP to the Royal Edinburgh Hospital two months prior to his actual admission. At this point an admission had been suggested but he had been reluctant. He related his referral as follows:

> And Dr ... asked me some questions and after that he says come back on the third of June. Well, I went back and he told me I'd need to come in and I says I wouldnae come in and I went home and says to the wife I think I can fight this myself. But I couldnae do it. She (wife) wanted me to come in the last time. She thought I was bad. I told my wife I wasnae going in.

Nine of the eleven subjects in this category were male, which partly reflects the predominance of males with drinking problems. It may also be that the ability to resist pressure from significant others and to delay seeking help is easier for males than for females.

As was suggested above, it is possible that the subjects in the first category went through a similar process to these subjects; that is, they faced pressure from significant others, but they did not express their subjective impressions of the process in this way. For the subjects in this category, it was not only a general recognition that a problem was adversely affecting their functioning which led them to seek help, but also increasing pressure from others and /or a precipitating crisis resulting in admission of failure. Again this may be partly accounted for by the type of problem which these subjects

were suffering from. It seems likely that their drinking problems adversely affected their relationships and hence the pressure from significant others.

It is likely that being male and having a drinking problem are the most important variables determining this type of illness behaviour and therefore inclusion in this category.

(c) Subjects who were Motivated to Seek Help but who felt a Lack of Control over the Process Leading to the Psychiatric Admission

Fourteen subjects in this research said they had considered that they had a problem and had initially been motivated to seek help for this, but who, in retrospect, felt a lack of control when it came to decisions regarding their referral and their admission.

One subject in this category had drinking problems and another had problems with drugs. The rest said they were suffering from depression, anxiety, 'nerves' or just generally 'feeling bad'. Four initially came in contact with the medical profession because of what they considered to be physiological problems. They, and the other subjects in this category were referred through various stages during which they remained passive and compliant before being admitted to a psychiatric facility.

A number of these subjects said they delayed seeking help because significant others tried to help them deal with their problems. One Edinburgh subject, for example, said that she had felt extremely depressed for the three months prior to her admission but her daughter had encouraged her to try and deal with the problem by herself. She said:

> I don't think you can get better by yourself. I think you need some sort of help. Well my daughter said to me, 'Help yourself, Mum, keep thinking that you're going to be better'. And I tried but it didn't work. 'Think nicely' she said, you know, 'Think pleasant things, and you'll be OK.

Eventually this subject decided, and her husband agreed, that her problems were not improving and she returned to her GP. He referred her to the Royal Edinburgh Hospital where she agreed to an admission when it was suggested.

When a referral to a psychiatrist or an admission was suggested to these subjects, they tended to agree on the basis that these professionals must 'know best' - they complied with what they perceived as their superior knowledge and expertise. Unlike those in category (b), they did not associate feelings of failure with the admission of needing medical help.

According to the subjects, significant others were supportive of whatever decision was made once help had been sought. They were also seen as having been compliant and did not appear to have acted as definers of illness like the family, friends or neighbours involved with the subjects in category (b).

Even where the subjects had thought that their problem was physiological, a psychiatric referral or admission was accepted as appropriate - again indicating their compliance.

One Newfoundland subject who had sought help for physical symptoms recalled her response to being told of her transfer to the psychiatric unit in the Health Sciences Centre:

> On Monday morning he (medical specialist) showed up and he said, 'I'm going to put you, you'll be treated by Dr ... (psychiatrist) for a while'. And so I made up my mind as to whatever he said I would do. I said, 'Fine, Dr ..., whatever you say'. I went along with them.

It is possible of course that these subjects, perhaps because of their age and the type of problem from which they were suffering, were dealt with differently in the medical and psychiatric consultation from the subjects in category (a) - that is they may not have been offered a choice and therefore did not feel as if they had actively participated in decisions.

However, other subjects in this research described the alternatives offered by the psychiatrists in similar ways. It is likely that their perceptions of their experiences reflect more their own attitudes than any differences in the medical encounter.

An illustration of this lack of choice was described as follows:

> I said, 'Do I have to come in?' He (psychiatrist) said, 'I want you in. You can come in as an out-patient but I'm not suggesting it'. He made it very clear what he wanted. I could have went as an out-patient but I took his advice. I thought, he's not a professor for nothing and obviously he's seeing more than I am, that I know. So I'll take the man's advice and come in. I must be doing the best thing for the long-term.

(d) <u>Subjects who had Considered that they had a Problem but who did not Seek Help and who were Admitted to Hospital after being compelled by the Actions of Other People</u>

Not all subjects in this research described the process leading to their admission as one in which they had been seeking help or advice for a problem. There were 11 who, despite having considered that they

had a problem, had either avoided seeking help or had refused to seek help and who felt compelled into a psychiatric admission by actions taken by family members, friends, neighbours, the police or members of the medical profession. These subjects did not feel that they had participated in any decisions taken in this process.

In three of the 11 cases, the subjects were taken or referred to hospital for what would appear to be similar problems to those of the rest of the sample. They were depressed; the only difference being that they themselves did not seek help for their problems and appear to have shown no indication of seeking help. One Newfoundland subject who admitted, when interviewed, that he had been extremely depressed said he had locked himself in his bedroom and refused to speak to anyone. His family called their doctor to the house and the subject was subsequently admitted directly to hospital.

> Well I didn't really come here on my own will. I guess it was for my own good because I was really depressed. My parents and my brother-in-law phoned the doctor and he suggested that I come here. So after a long argument like I came in anyway. I have to admit it now I was as far gone as I want to be. I couldn't take much more.

According to most of the subjects in this category, they had exhibited behaviour which was visible and was considered by significant others to be disruptive. Five of the 11 had consumed alcohol which resulted in the behaviour precipitating the action taken by significant others. One young woman had become upset when her husband left her. Her neighbour had taken her to her GP and, according to this subject's perception, had also been fairly influential in the decision regarding the psychiatric referral to the Royal Edinburgh Hospital.

> My neighbour took me down because I was actually a bit depressed and I'd actually taken a few drinks. Took me down to see Dr ... and he said to ... (neighbour) 'There's no point in sending her, they won't help her, she doesn't need to go'. And ... (neighbour) says, 'Well, she's got the child to consider as well'. I don't think if she hadn't been with me he would have sent me at all. I think she pushed the matter. He said, 'Well, fair enough'.

In five cases the subjects consulted their GPs or family doctors at their offices. However, they said they were taken there by family, friends or neighbours and in some instances these significant others had first contacted the physicians. None of these subjects made the initial contact themselves. In another three instances, significant others called the family doctors to the subject's home. All of these subjects, then, were referred immediately or were taken to the psychiatric hospital and were admitted the same day. Another two of these subjects were taken directly to the psychiatric hospital by significant others. In the eleventh case, the subject's wife telephoned the police and a psychiatric admission followed soon after.

Significant others, then, were extremely influential not only in defining the behaviour as problematic but also in some cases as defining it as a psychiatric problem. There appear to have been no delays from the point at which significant others initiated help seeking and the psychiatric admission. Where filters were not bypassed, they were passed through with considerable haste.

Six of the eleven had received psychiatric out-patient treatment at some time in the past. Although the influence of the type of behaviour exhibited by the subjects or their general conditions should not be discounted, it seems that significant others were more likely

to take direct action rather than simply pressurising the individuals to seek help when they knew that they had previously had psychiatric out-patient treatment and that their problems had previously been defined as psychiatric. In effect they were labelling the individuals as mentally ill. Family doctors may have responded in a similar way, thus bringing them directly to psychiatric attention. The individuals themselves because of having previously been labelled as mentally ill as a result of their psychiatric out-patient experience were probably resistant to seeking help because of a fear of further labelling.

All of these subjects indicated that they felt coerced into the psychiatric admission, although none were admitted on a compulsory or involuntary basis. Despite this pressure, they had, for the most part, accepted and rationalised the decision, at least by the time they were interviewed.

(e) Subjects who had not Considered that they had a Problem who were Admitted to Hospital after being compelled by the Actions of Other People

There were ten subjects who were similar to the subjects in category (d) in that they had neither been seeking help nor did they feel they had actively participated in any decision regarding their referral or their admission. They too felt they had been compelled by the actions of significant others, the police or members of the medical profession into their psychiatric admission. The subjects in this category, however, were different in that they said they had not considered they had a problem at the time.

For example, one Newfoundland subject said she thought she had been, and was still, 'down' but prior to her admission she had considered only

that she was tired. She said she had not been seeking help for herself but had been trying to obtain a psychiatric admission for her husband, who she considered to be an alcoholic when he in turn arranged to admit her.

> My husband phoned here to see if he could get a doctor to straighten me up inside and I wanted to rest. I mean I was tired because I was trying to get help for him. I mean we came here to straighten him up, right, and well I wanted him straightened up.

Only one of these subjects was admitted on an involuntary basis, although the police had been involved in the admissions of four of the six Newfoundland subjects in this category. They are similar to the subjects in category (d) in that in at least six instances visibly disruptive behaviour would appear to have been involved. Alcohol consumption was involved in three cases. These subjects had denied at the time that their behaviours were problematic and most continued to think this.

These subjects too felt that they had been placed under considerable pressure to admit themselves, particularly by the psychiatrists. These subjects, like those in category (d) either bypassed filters on the route to the psychiatric hospital or passed through them quickly. Even in the three cases where they consulted GPs or family doctors at their offices, an admission followed swiftly. In one of these three situations the family doctor telephoned the police who then took the subject to hospital. In another case the GP visited the subject in her own home. Another two of these subjects were taken directly to hospital by significant others, and three were taken to hospital by the police after the police had been contacted by significant others. In

the remaining case, a neighbour telephoned the subject's GP who sent an ambulance which took the subject to hospital.

Unlike category (d), these subjects had not received psychiatric out-patient treatment in the past. It is unlikely therefore that significant others, GPs or the police based their decisions on previous definitions of the subjects' problems as psychiatric. Given the routes taken to the hospitals, the involvement of the police, and the fact that these subjects denied they had a problem, it is likely that behaviours were disruptive or perceived to be serious and that the individuals demonstrated some resistance. GPs or family doctors certainly played some part in defining these subjects' problems as psychiatric, but significant others and the police were not without influence.

From their admission processes these 10 subjects appear to be those most likely to resist and oppose psychiatric treatment. They thought they had played no part in the decisions regarding their admissions and felt they had no choice in the matter. None was seeking help of any kind at the time and they did not think psychiatric help was required.

(f) Subjects Admitted after Receiving Psychiatric Out-Patient Treatment

As was mentioned above, the dynamics of problem recognition for those subjects admitted to hospital after receiving psychiatric out-patient treatment or after a suicide attempt are thought to be somewhat different from those of the subjects discussed in the above five categories and are discussed separately.

There were 14 subjects who had been receiving psychiatric out-

patient treatment for a considerable period of time prior to their admission and the process leading to the definition of their problems as in need of psychiatric treatment is not known. Nevertheless, this group is of some interest here in that the processes leading up to their admissions were similar to those of other subjects in this research. Two of these 14 were admitted to hospital after a suicide attempt and will also be discussed below. The nine subjects who had been seen on an out-patient basis in Newfoundland had generally been consulting on this basis for a longer period of time than their equivalents in Edinburgh.

Basically these subjects were similar in attitude to the rest of the sample in that either they were seeking help, they felt they had been compliant or they felt they had been coerced into their admission.

There were six of these subjects who defined the process in terms of their having been 'help seekers' - they either perceived themselves as having been self-motivated or they felt that they had been pressurised by significant others at some point. In this they are similar to the subjects in categories (a) and (b). Two agreed to a psychiatric admission after a number of delays, initial reluctance and pressure from significant others.

One Newfoundland subject who had been seen on an out-patient basis for the previous ten months said that he contacted his psychiatrist and requested an admission.

> I was having a period of desponses (sic), of despondent and depressed, because of several factors in the past few months. So I came here to seek help. And an appointment was made to see Dr ... But I only had the two visits until I asked to be admitted yesterday.

There were three who were basically compliant - similar to those in category (c) - and accepted an admission when it was suggested by their psychiatrist. For example, one subject when asked if he felt pressurised into a psychiatric admission said:

> No, he (the psychiatrist) suggested that I come in. He never pressured me. He thought it best.

Another five subjects, including the two parasuicides, felt that they had been coerced or admitted under considerable pressure from their psychiatrists. Three of these five were admitted on an involuntary basis. One explained:

> I wasn't under pressure because I had no choice. He just came in and said the arrangements have been made and you're going and that's it.

Two of these 14 had problems with drinking or drugs and the remainder were suffering from depression or anxiety.

(g) Parasuicides

Twenty three subjects were admitted to hospital after a suicide attempt. They are considered here as a distinct group because of the nature of the actual admission procedure. For most of these subjects, particularly those in the Edinburgh sample, it was the act itself which

was perceived as precipitating the admission rather than a process of problem recognition or negotiation with significant others or GPs.

Not all parasuicides are referred for psychiatric in-patient treatment. The statistics available for Edinburgh indicate that in 1979 approximately 16% of males and 13% of females admitted to the Regional Poisoning Treatment Centre were referred for such treatment (Kreitman et al., 1980). Indeed these statistics indicate that not everyone is referred to a psychiatrist even on an out-patient basis. Attempted suicide is apparently not considered to equate psychiatric disorder. The parasuicides in this research, then, are representative only of a minority of people admitted to hospital because of a suicide attempt.

Some of these parasuicides appear to have gone through similar processes, in terms of problem recognition and help seeking, to other subjects in this research. Certainly some had considered they had a problem for which they had sought medical help. Of the 13 Edinburgh parasuicides, there were three who said they were already attending their GPs on a regular basis and were being prescribed psychotropic medication; another two were waiting for an admission to the Unit for the Treatment of Alcoholism at the Royal Edinburgh Hospital and one was receiving psychiatric out-patient treatment. Two of the 13 had received psychiatric out-patient treatment at some time in the past for the same or a similar problem. Three of the 13 had taken drug overdoses previously but had not been admitted to a psychiatric hospital. For one subject - the only compulsory Edinburgh subject - the first suicide attempt had been two days prior to the attempt which precipitated the admission.

The ten Newfoundland subjects were similar in terms of help seeking for perceived problems. One of these ten had recently discussed with her doctor the possibility of a psychiatric admission. She had also received psychiatric out-patient treatment in the past. Two subjects were attending their GPs regularly and receiving psychotropic drugs; one was consulting a psychologist on a regular basis; another was receiving psychiatric out-patient treatment and another had discussed with a friend the possibility of seeking an admission to Waterford Hospital.

Some of these patients were similar to those in category (d) or (e), where significant others or other agencies took some direct action which led to the psychiatric admission. They did not pass through all the filters described by Goldberg and Huxley (1980) and appear to have short circuited the process by their suicide attempts. Similarly, those who said they had discussed their problems with significant others and had thought about seeking help or had actually sought help, had not pursued this to the point where they passed through all filters and levels.

Of interest is that nine parasuicides specifically said they had been unable to talk to significant others about their problems and had not done so prior to their suicide attempts. Others appear not to have entered into negotiations with significant others which might have led to their being motivated to seek help and nor were they pressurised by significant others into this.

Of the 13 parasuicides in Edinburgh, 12 were first admitted to the Regional Poisoning Treatment Centre in the Royal Infirmary of Edinburgh and were then transferred after a psychiatric consultation

to the Royal Edinburgh Hospital. The other subject was seen at the accident and emergency unit in Leith Hospital and transferred to the Royal Edinburgh Hospital the same day (Table 7:1). Five of these 13 were admitted to the 'North Wing' - a unit at the Royal Edinburgh Hospital with an admissions arrangement with the Poisoning Treatment Centre. The other subjects were admitted to 'sector' wards. The one compulsory subject in the Edinburgh sample was admitted first to a locked ward because of his resistance to his admission and then transferred the following day to an open 'sector' ward. Twelve of these 13 subjects had taken overdoses of some type of drug and one of the 12 had also attempted to hang himself. The other subject was admitted to hospital after trying to gas himself.

The decision regarding a psychiatric admission for all of these subjects took place while they were in either the Royal Infirmary of Edinburgh or Leith Hospital. Five of the parasuicides specified that they had discussed their transfer to the Royal Edinburgh Hospital with a psychiatrist at the Royal Infirmary and four said that this discussion had been with a 'doctor'. Another had discussed her transfer with a social worker and her lawyer. The remaining three did not specify the staff member with whom they discussed their psychiatric admission. Significant others appear to have played a minor role in influencing decisions at this point.

In contrast, the decision regarding a psychiatric admission for the Newfoundland subjects was taken at different stages depending on the nature of the involvement of other people, on the participation of the individuals themselves and on what decision was made concerning which hospital to take the individual to. All ten of the

Newfoundland parasuicides had taken drug overdoses.

Two of these ten parasuicides were admitted directly to Waterford Hospital having had no medical or psychiatric consultation from the time of their suicide attempt until they were seen at the hospital. The first of these had been taken to Waterford Hospital by a friend and the other by his mother, his wife and his sister. Another two subjects were taken by the police to Waterford Hospital. Both these were admitted on an involuntary basis. Another 'involuntary' parasuicide was admitted to Grand Falls Hospital (a general hospital in another part of the Province) after her suicide attempt and transferred immediately to Waterford Hospital.

The other five Newfoundland parasuicides were admitted to the Health Sciences Centre Psychiatric Unit and were all 'voluntary' patients. Three of these five were taken by family members to the emergency unit at that hospital and later transferred to the psychiatric unit. The fourth had been taken to a local hospital by her family and was then transferred. The fifth had taken an overdose of drugs and then consulted her family doctor. Her condition was not considered serious enough to warrant immediate hospitalisation but her family doctor referred her to the Health Sciences Centre Psychiatric Unit where she was seen three days later and admitted (Table 7:2).

Basically, these subjects were similar to others in the research in terms of their attitudes towards their psychiatric admission. They described themselves in terms of either being 'help seekers' or they felt they had been compliant or they felt pressurised and even coerced into an admission.

Six of the 23 parasuicides were similar to the 'help seekers' described earlier, although only four of these unequivocally said that they had wanted a psychiatric admission. One who had been taken to Waterford Hospital by his family when asked if he had felt under any pressure regarding an admission said:

> No, I was just coming in here, that's it. But they (family) thought, they didn't think I was going to come in and I said, 'Bring me in, bring me in and sign me in. I wants to get rid of this'. So.

Eight of the 23 described their admission or transfer to the psychiatric hospital or unit as one in which they had essentially been compliant. They said that when a psychiatric admission was suggested to them or when they were told they were to be admitted or transferred, they accepted it but without feeling either that they had participated in this decision or that the decision had been imposed upon them. Like the subjects in category (c), they accepted the psychiatrists' authority and the decisions made as appropriate. For example, one subject when asked about the decision concerning the psychiatric admission said:

> Of course I could have said I'm not going to go in, but he was a doctor, that, I dinnae ken, I just trust him.

Of course the process may have been perceived in this way because of the subjects' state of mind at the time. They may have been extremely depressed and may have been making serious suicidal gestures. One subject said:

> I wasn't very fussy where I went, to be perfectly truthfully. That was the state of mind I was in, because I didn't expect to be in the Royal Infirmary.

Six parasuicides felt they had been compelled to admit themselves and felt they had been coerced into this. Four of these six were admitted on an involuntary or compulsory basis and the fifth said he was given the alternative of admitting himself voluntarily, or being admitted on a compulsory basis. The sixth said that although such an alternative was not made explicit, she felt that she had no choice in the matter.

> Well there wasn't much of a choice. The thing was there was a psychiatrist there and she said 'Well if we let you out are you going to do it again?' And you know I didn't think at the time. I really wasn't thinking straight. I said, 'Oh, yes I would' and she said, 'You're going to Craig House'.

Two of these six were the two parasuicides who were also receiving psychiatric out-patient treatment prior to this incident.

Finally, three of the Newfoundland subjects said they had been compelled by virtue of the fact that by the time they had fully regained consciousness they had already been admitted to hospital. This would have been a less likely occurrence in the Edinburgh sample because of the admission process and the time lapse between their admission to the Regional Poisoning Treatment Centre and their referral to the Royal Edinburgh Hospital.

Consultation with Significant Others and Non-medical Professionals

Freidson (1961) found that if a complaint from which a person was suffering was 'not pressing or self-evident' that there was a tendency for consultation outside the individual's household. Forty of the subjects in this research appear to have involved themselves in such a lay referral system but it was not generally recalled as having been of crucial importance in the decision to seek help.

In most instances subjects consulted people with whom they had a close confiding relationship - family members or friends. For most married subjects this was their spouse, although some other family members were also perceived as having played an active role. Newfoundland subjects appear to have extended this lay consultation to a wider selection of family members but this probably reflects the nature and dynamics of social networks in Newfoundland, rather than any uncertainty about the nature of emotional problems and the need for reassurance about help seeking.

Four subjects said they consulted superiors at work but it seems from the evidence given that such consultations took place because the subjects' problems were in some way affecting their performance as employees rather than because the employers were perceived as authorities to consult on such matters.

The literature on attitudes towards help seeking and help seeking behaviour often cites the clergy as an important help source for emotional problems. Elinson et al (1967), for example, found that 17% of their sample cited the clergy as a help source for a hypothetical problem. In a Scottish study by Gordon et al (1979), 11% of the subjects studied had actually consulted their Minister about their

problems. In this research, however, only one subject mentioned that a Minister was consulted.

Contrary to what is suggested in the literature, non-medical specialists were not seen by these subjects as appropriate persons to consult for emotional problems. Social workers, clergy, lawyers, marriage guidance counsellors, citizen's advice bureaux, public health nurses and teachers all tended to be seen as appropriate only for their own specialties and not for general emotional problems. Only GPs were cited as appropriate and even they were considered to be important only in terms of referral to psychiatry. As far as actually dealing with emotional problems, they were considered to have too little time, to be too busy, to be disinterested or lacking in knowledge. All of this probably partially reflects the subjects' own personal experiences.

Not all subjects in this research described significant others as having played a part in the route to the hospital. Thirty three subjects did not describe significant others as having been actively involved in discussing problems or in encouraging them to seek help. This lack of consultation can be partly accounted for by the living situations and marital status of these individuals. Of the 18 in Edinburgh, 11 were male and single, separated or divorced. This is out of a total of 18 such males in the Edinburgh sample. Another two of these 18 were females in similar situations.

A different picture emerges for the 15 Newfoundland subjects who did not mention significant others as having played an important part in problem recognition and in encouraging help seeking. Surprisingly ten of the 15 were female. Seven of these were also married and

living with their husbands, but none mentioned their husbands with regard to problem recognition. A possible explanation for this would be that for females living in a society characterised by extended and close family networks, other female relatives would be the significant others to turn to in dealing with illness, rather than spouses. They did not appear to have done this. Two said they had talked to friends about their problems but they did so in a general way and there had been no encouragement to seek help. One other had discussed her problems with her superior at work. It is possible that either the subjects' illnesses were such that they were unable to discuss their feelings or that they generally saw it as inappropriate to discuss such things. It is also possible that this lack of consultation reflects a general lack of awareness regarding emotional problems.

Where significant others were not perceived as having been involved - in both Edinburgh and Newfoundland - two alternative routes to hospital appear to have been followed. They were either self-motivated help seekers or a suicide attempt precipitated their admission.

Much of this lack of lay referral or of extended lay referral may be accounted for by fear. It is likely that the embarrassment and fear relating to emotional problems in general, to psychiatric disorder in particular and to psychiatric hospitals might have deterred these subjects from consulting other people or from extending this to people outside their households. For many this was because of the stigma associated with psychiatric disorder and psychiatric hospitals. These subjects' feelings about stigma will be explored in Chapter 9.

Subjects' Characteristics and Perceptions of the Admission Process

The distribution of subjects among the categories relating to the admission process is summarised in Table 7:3.

TABLE 7:3 Subjects' Perceptions of the Admission Process

Perceptions of the Admission Process	Number of Subjects
(a)	19
(b)	11
(c)	14
(d)	11
(e)	10
Parasuicides	23
Out-patient admissions	14
Total	102

The total includes two subjects coded as both parasuicides and as out-patient admissions. The subsequent analysis considers them as parasuicides.

Three broad categories will also be considered here. These include those who saw themselves as seeking help (a) and (b), those who felt compliant (c) and those who felt they had been compelled into their admission (d) and (e). As was suggested above, the parasuicides and those admitted to hospital after a period of out-patient treatment may also be considered as similar to other subjects in terms of their perceptions of the admission process. They too felt that they had been seeking help or that they had been compliant or that they had been compelled into their admission. They are counted in the following analysis as being in one of these three broad categories.

Table 7:4 shows the distribution of parasuicides and out-patient admissions in these three broad categories. The three parasuicides who

had been unconscious at the time of their psychiatric admission and who felt coerced into the admission because of this are coded as having felt 'compelled'.

TABLE 7:4 Parasuicides' and Out-patient Admissions' Perceptions of the Admission Process

Perceptions of the Admission Process	Parasuicides	Out-patient Admissions	Total
Help seeking	6	6	12
Compliant	8	3	11
Compelled	9	3	12
Total	23	12	35

Out-patient admissions here and in subsequent tables = 12. The two such subjects who were also parasuicides are coded as parasuicides.

The subjects subscribing to the above discussed categories may again be considered in terms of a number of characteristics.

As can be seen in Table 7:5, Edinburgh subjects were more likely than Newfoundland subjects to subscribe to categories (a) and (b). They were more likely to have recognised that they had a problem and been motivated to seek help for it or to have been motivated to seek such help after being put under pressure by other people to do so. Table 7:5 also shows that Newfoundland subjects slightly more than Edinburgh subjects subscribed to categories (c), (d) and (e). They were more likely: to have felt a lack of control when it came to making decisions regarding their admission although they felt initially motivated to seek help (c); to have felt they had been compelled into the admission although they recognised they had a problem (b); or to have not thought that they had a problem and to have felt compelled into their psychiatric admission (e).

TABLE 7:5 Subjects' Perceptions of the Admission Process (all categories) by Location

Perceptions of the Admission Process	Location Edinburgh	Newfoundland	Total
(a)	11 (22.0%)	8 (16.0%)	19
(b)	7 (14.0%)	4 (8.0%)	11
(c)	6 (12.0%)	8 (16.0%)	14
(d)	5 (10.0%)	6 (12.0%)	11
(e)	4 (8.0%)	6 (12.0%)	10
Parasuicides	13 (26.0%)	10 (20.0%)	23
Out-patient admissions	4 (8.0%)	8 (16.0%)	12
Total	50	50	100

Table 7:6 shows that Edinburgh (48%) more than Newfoundland subjects (36%) saw themselves as having sought help. Newfoundland subjects (40%) more frequently felt they had been compelled into their admissions (Table 7:6). It is possible that this pattern reflects a greater acceptance of psychiatric treatment among Edinburgh subjects. This may have been because of a greater understanding of such treatment among these subjects. However, as was mentioned above, the actual level of knowledge of psychiatry among the majority of subjects in this research was too limited to be considered in the analysis. Acceptance, then, is unlikely to have been based on actual knowledge. It seems possible that the different patterns reflect less anxiety on the part of a greater number of Edinburgh than Newfoundland subjects about being admitted to a psychiatric hospital and less anxiety about becoming a psychiatric patient.

TABLE 7:6 Subjects' Perceptions of the Admission Process (combined categories) by Location

Perceptions of the Admission Process	Location Edinburgh	Newfoundland	Total
Help seeking	24 (48.0%)	18 (36.0%)	42
Compliant	13 (26.0%)	12 (24.0%)	25
Compelled	13 (26.0%)	20 (40.0%)	33
Total	50	50	100

$x^2 = 4.018$, df = 2, n.s.

It was suggested in Chapter 5 that the way these subjects described mental illness and the mentally ill reflected how they themselves felt about being labelled as such and the possible consequences of this. From this it seems likely that their feelings about the admission process itself would be related to these different descriptions.

The distribution of views about the nature of mental illness and perceptions of the admission process is shown in Table 7:7. Subjects who described the mentally ill in terms of a negative stereotype only - as unpredictable and non-understandable and perhaps dangerous - more often than others felt compliant about their admission (c) (26.7%) (Table 7:7). Category (e) - seeing the admission process as one in which they had been compelled and where they had not recognised that they had a problem - was also subscribed to by subjects describing mental illness in terms of a negative stereotype only (16.7%) and by those who described mental illness only in terms of depression or anxiety (15.4%) (Table 7:7). Those who saw themselves as having

sought help, either having been self motivated (a) or having been initially pressurised by others (b) tended most frequently to be those who described mental illness as a wide range of conditions (27.0% and 21.6%, respectively) (Table 7:7).

Again, the numbers are very small, but subjects admitted after psychiatric out-patient treatment tended less frequently to describe mental illness in terms of a negative stereotype only than either of the other two views (Table 7:7). This possibly reflects attitudes learned through experience.

TABLE 7:7 Subjects' Perceptions of the Admission Process (all categories) by Conceptions of Mental Illness

Perceptions of the Admission Process	Conceptions of Mental Illness: Stereotypes	Depression/ Anxiety	Both	Total
(a)	2 (6.7%)	4 (15.4%	10 (27.0%)	16
(b)	2 (6.7%)	1 (3.8%)	8 (21.6%)	11
(c)	8 (26.7%)	3 (11.5%)	2 (5.4%)	13
(d)	5 (16.7%)	2 (7.7%)	3 (8.1%)	10
(e)	5 (16.7%)	4 (15.4%)	-	9
Parasuicides	6 (20.0%)	8 (30.8%)	8 (21.6%)	22
Out-patient admissions	2 (6.7%)	4 (15.4%)	6 (16.2%)	12
Total	30	26	37	93

Totals are less than 100 because of those not coded on 'conceptions'

When the categories are combined into those seeking help, those who felt compliant and those who felt compelled, and when the parasuicides and out-patient admissions are included, a clear pattern emerges. Table 7:8 shows a relationship between perceptions of the admission process and conceptions of mental illness significant at the .05 level.

It appears that those who described mental illness as a broad range of disorders (62.2%) were much more likely than either of the other two groups to describe the admission process as one in which they had been seeking help (Table 7:8). Again, this would seem to indicate less anxiety about becoming a psychiatric patient and an acceptance of psychiatry. This is consistent with the findings in the two locations where a greater proportion of Edinburgh subjects both saw themselves as 'help seekers' (Table 7:6) and described mental illness as a broad range of conditions (Table 5:8).

By way of contrast, Table 7:8 also shows that those who described mental illness in terms of a negative stereotype only were more likely to have felt compliant (36.7%) or compelled into the admission (40.0%) than to have seen themselves as seeking help (23.3%). This possibly reflects greater anxiety about the meaning of becoming a psychiatric patient.

TABLE 7:8 Subjects' Perceptions of the Admission Process (combined categories) by Conceptions of Mental Illness

Perceptions of the Admission Process	Conceptions of Mental Illness: Stereotypes	Depression/ Anxiety	Both	Total
Help seeking	7 (23.3%)	9 (34.6%)	23 (62.2%)	39
Compliant	11 (36.7%)	7 (26.9%)	6 (16.2%)	24
Compelled	12 (40.0%)	10 (38.5%)	8 (21.6%)	30
Total	30	26	37	93

$x^2 = 11.287$, $df = 4$, $p < 0.05$

It might have been expected that the subjects' views on aetiology would relate to their feelings about the admission process. These two variables are considered in Table 7:9. Those assigning blame or responsibility to the individual for causing his or her illness were more likely than others to have considered that they had a problem and to have felt compelled into their psychiatric admission (d). This could be an indication of anxiety. Table 7:9 also shows that those who gave more than one explanation for the causes of mental illness ('multi-category' subjects) did not tend to feel that they were compelled into their admissions. Again this likely reflects an acceptance of psychiatry.

TABLE 7:9 Subjects' Perceptions of the Admission Process (all categories) by Beliefs about the Aetiology of Mental Illness (combined categories)

Perceptions of the Admission Process	No Individual Blame (a) (b) (c)	Individual Blame (d) (e) (f)	Multi-Category	Total
(a)	7 (21.2%)	7 (14.3%)	3 (30.0%)	17
(b)	2 (6.1%)	7 (14.3%)	2 (20.0%)	11
(c)	4 (12.1%)	5 (10.2%)	2 (20.0%)	11
(d)	2 (6.1%)	9 (18.4%)	-	11
(e)	2 (6.1%)	5 (10.2%)	1 (10.0%)	8
Parasuicides	10 (30.3%)	11 (22.4%)	1 (10.0%)	22
Out-patient admissions	6 (18.2%)	5 (10.2%)	1 (10.0%)	12
Total	33	49	10	92

Totals are less than 100 because of those not coded on 'aetiology'

While assigning blame was thought to be somewhat associated with a negative attitude towards mental illness and the mentally ill (Table 6:5) the distribution in Table 7:10 shows that those who assigned blame in aetiology were almost equally as likely to see

themselves as having sought help (38.8%) as to having been compelled into their psychiatric admissions (36.7%). However, those who did not assign blame to the individual were most likely to see themselves as help seekers (48.5%). This may reflect a lack of guilt and anxiety about becoming a psychiatric patient.

TABLE 7:10 Subjects' Perceptions of the Admission Process (combined categories) by Beliefs about the Aetiology of Mental Illness (combined categories)

Perceptions of the Admission Process	No Individual Blame (a) (b) (c)	Individual Blame (d) (e) (f)	Total
Help seeking	16 (48.5%)	19 (38.8%)	35
Compliant	8 (24.2%)	12 (24.5%)	20
Compelled	9 (27.3%)	18 (36.7%)	27
Total	33	49	82

$x^2 = 0.971$, df = 2, n.s.
Totals are less than 100 because of those not coded on 'aetiology' and because the 'multi-category' subjects are not included

The distribution of psychiatric experience and perceptions of the admission process is seen in Table 7:11. Those with little of such experience more often felt that they had sought help and had initially been motivated to do so (a). They were also more likely than those with 'high' psychiatric experience to have felt compelled into their psychiatric admission and not to have considered that they had a problem (e) (Table 7:11). It may be that those who did not recognise that they had a problem (e) did not because of a lack of past experience with which to compare their present condition.

TABLE 7:11 Subjects' Perceptions of the Admission Process (all categories) by Experience of Psychiatry

Perceptions of the Admission Process	Experience of Psychiatry Low	High	Total
(a)	12 (24.0%)	7 (14.0%)	19
(b)	6 (12.0%)	5 (10.0%)	11
(c)	8 (16.0%)	6 (12.0%)	14
(d)	4 (8.0%)	7 (14.0%)	11
(e)	8 (16.0%)	2 (4.0%)	10
Parasuicides	12 (24.0%)	11 (22.0%)	23
Out-patient admissions	-	12 (24.0%)	12
Total	50	50	100

When the combined categories are considered, little emerges (Table 7:12). Those with 'high' experience were slightly less likely than those with 'low' experience to see themselves as help seekers (40% compared to 44%) and slightly more likely to consider that they had been compelled into their admissions (36% compared to 30%).

TABLE 7:12 Subjects' Perceptions of the Admission Process (combined categories) by Experience of Psychiatry

Perceptions of the Admission Process	Experience of Psychiatry Low	High	Total
Help seeking	22 (44.0%)	20 (40.0%)	42
Compliant	13 (26.0%)	12 (24.0%)	25
Compelled	15 (30.0%)	18 (36.0%)	33
Total	50	50	100

$x^2 = 0.408$, df = 2, n.s.

Table 7:13 shows the relationship between sexual status and the admission process. It appears that females (5.1%) were less likely than males (14.7%) to feel that they had sought help after being pressurised to do so by other people (b). This possibly reflects the number of male subjects in this category with problems related to alcohol consumption. These subjects, as was discussed above, frequently delayed seeking help, often attempting to deal with the problem by themselves. Males (13.1%) were also more likely than females (7.7%) to have felt that they had been compelled by others into their admission, although they themselves had considered that they had a problem (d) (Table 7:13). It may be, as with those in category (b), that it is easier for men than women to resist pressure to seek help in these instances, to the point where other people initiate action towards hospitalisation.

Table 7:13 also shows that a greater percentage of females than males (20.5% compared to 9.8%) felt compliant in the admission process. This may reflect general feelings of passiveness and acceptance vis-a-vis the medical profession. It also likely reflects the greater proportion of female subjects suffering from depression and who possibly felt passive as a result of this condition.

TABLE 7:13 Subjects' Perceptions of the Admission Process (all categories) by Sexual Status

Perceptions of the Admission Process	Sexual Status Female	Male	Total
(a)	7 (17.9%)	12 (19.7%)	19
(b)	2 (5.1%)	9 (14.7%)	11
(c)	8 (20.5%)	6 (9.8%)	14
(d)	3 (7.7%)	8 (13.1%)	11
(e)	4 (10.3%)	6 (9.8%)	10
Parasuicides	11 (28.2%)	12 (19.7%)	23
Out-patient admissions	4 (10.3%)	8 (13.1%)	12
Total	39	61	100

The literature argues that females more than males are more likely to seek help for problems. However, as can be seen from Table 7:14, it was male (47.5%) subjects in this research who were most likely to see themselves as having sought help. Female subjects were more equally distributed among the three categories but saw themselves as compliant (35.9%) considerably more than did males (18.0%).

Table 7:13 shows that over a quarter (28.2%) of all the female admissions in this sample were admitted to hospital after a suicide attempt. This may also indicate that females are less likely than the literature suggests to seek help for emotional problems.

TABLE 7:14 Subjects' Perceptions of the Admission Process (combined categories) by Sexual Status

Perceptions of the Admission Process	Sexual Status Female	Male	Total
Help seeking	13 (33.3%)	29 (47.5%)	42
Compliant	14 (35.9%)	11 (18.0%)	25
Compelled	12 (30.8%)	21 (34.4%)	33
Total	39	61	100

$x^2 = 4.277$, df = 2, n.s.

When the subjects' ages and perceptions of the admission process are examined a few points emerge. Those most likely to feel they had been compelled into the admission when they had considered that they had a problem (d) were the subjects aged 30-44 (25.0%) (Table 7:15). Table 7:15 also shows that those over 45 did not subscribe to this view at all and they were most likely to have seen the admission process as one where they had been motivated to seek help but also felt a lack of control when it came to decisions regarding their referral and admission (c) (25.9%). These subjects probably held more traditional views of medicine, particularly concerning the role of the patient in decision making. They might have been dealt with differently by the medical profession in the past when the system may have been more traditional. Their views may have been based on this experience. The parasuicides in this research tended to be among those under 44 and over half were in the youngest age group.

TABLE 7:15 Subjects' Perceptions of the Admission Process (all categories) by Age

Perceptions of the Admission Process	Age 29 and under	30-44 years	45 and above	Total
(a)	7 (17.1%)	7 (21.9%)	5 (18.5%)	19
(b)	4 (9.8%)	3 (9.4%)	4 (14.8%)	11
(c)	4 (9.8%)	3 (9.4%)	7 (25.9%)	14
(d)	3 (7.3%)	8 (25.0%)	-	11
(e)	5 (12.2%)	1 (3.1%)	4 (14.8%)	10
Parasuicides	12 (29.3%)	7 (21.9%)	4 (14.8%)	23
Out-patient admissions	6 (14.6%)	3 (9.4%)	3 (11.1%)	12
Total	41	32	27	100

From Table 7:16 it appears that although older subjects were more likely than others to have felt compliant (40.7%) they were equally as likely to have seen themselves as seeking help. Those over 44 were least likely as a group to have felt compelled into the psychiatric admission (18.5%) (Table 7:16).

TABLE 7:16 Subjects' Perceptions of the Admission Process (combined categories) by Age

Perceptions of the Admission Process	Age 29 and under	30-44 years	45 and above	Total
Help seeking	16 (39.0%)	13 (40.6%)	11 (40.7%)	40
Compliant	8 (19.5%)	7 (21.9%)	11 (40.7%)	26
Compelled	17 (41.5%)	12 (37.5%)	5 (18.5%)	34
Total	41	32	27	100

$x^2 = 5.836$, df = 4, n.s.

Table 7:17 shows that married subjects (23.3%) slightly more frequently than unmarried subjects (15.8%) saw themselves as having sought help and being self-motivated in this (a).

They also more frequently subscribed to category (c) - feeling a lack of control when it came to decisions regarding the referral and admission despite having been motivated to seek help initially (18.6%). Unmarried subjects more frequently felt they had been compelled into the admission - both having and having not recognised that they had a problem (d) and (e) (12.3% and 14.0%, respectively) (Table 7:17).

TABLE 7:17 Subjects' Perceptions of the Admission Process (all categories) by Marital Status

Perceptions of the Admission Process	Marital Status: Unmarried	Married	Total
(a)	9 (15.8%)	10 (23.3%)	19
(b)	6 (10.5%)	5 (11.6%)	11
(c)	6 (10.5%)	8 (18.6%)	14
(d)	7 (12.3%)	4 (9.3%)	11
(e)	8 (14.0%)	2 (4.6%)	10
Parasuicides	14 (24.6%)	9 (20.9%)	23
Out-patient admissions	7 (12.3%)	5 (11.6%)	12
Total	57	43	100

The pattern is similar in the combined categories. In Table 7:18 it appears that while married subjects were only slightly more likely than others to see themselves as help seekers (44.2% compared to 40.4%), they were considerably less likely to have felt compelled into the psychiatric admission (20.9% compared to 42.1%). The relationship between age and the admission process is significant at the 0.05 level.

To some extent the pattern for marital status probably reflects that for age. Both married and older subjects less often felt compelled into the admission. The unmarried subjects in the sample tended to be younger than the married subjects because of the predominance of single, never married subjects in this group.

TABLE 7:18 Subjects' Perceptions of the Admission Process (combined categories) by Marital Status

Perceptions of the Admission Process	Marital Status Unmarried	Married	Total
Help seeking	23 (40.4%)	19 (44.2%)	42
Compliant	10 (17.5%)	15 (34.9%)	25
Compelled	24 (42.1%)	9 (20.9%)	33
Total	57	43	100

$x^2 = 6.364$, $df = 2$, $p < 0.05$

Table 7:19 shows that those with university or college education (32.0%) were more likely than others to have seen themselves as recognising they had a problem and being self-motivated in seeking help (a). They were less likely (8.0%) than the other two groups to have been initially motivated to seek help but feeling a lack of control over decisions regarding their referral and admission (c), or to have not recognised that they had a problem (e). It may be, then, that education is somewhat related to attitudes towards the admission and possibly the amount of control that the subjects felt they had in this process.

The parasuicides tended to have less than university or college education (Table 7:19).

TABLE 7:19 Subjects' Perceptions of the Admission Process (all categories) by Education Level

Perceptions of the Admission Process	Education Level 0-9 years	10-13 years	University/ College	Total
(a)	4 (11.4%)	7 (17.5%)	8 (32.0%)	19
(b)	6 (17.1%)	3 (7.5%)	2 (8.0%)	11
(c)	6 (17.1%)	6 (15.0%)	2 (8.0%)	14
(d)	1 (2.9%)	6 (15.0%)	4 (16.0%)	11
(e)	4 (11.4%)	5 (12.5%)	1 (4.0%)	10
Parasuicides	9 (25.7%)	10 (25.0%)	4 (16.0%)	23
Out-patient admissions	5 (14.3%)	3 (7.5%)	4 (16.0%)	12
Total	35	40	25	100

If education was clearly related to the amount of control which these subjects felt they had over the admission process, it might have been expected that those with fewest years of education would have been most likely to have felt compelled into their psychiatric admission. As Table 7:20 indicates, however, subjects with under nine years of schooling were less likely (25.7%) than the other two groups to have felt this way. But consistent with the findings in Table 7:19, those with university or college education were most likely to see themselves as having sought help (52.0%) and least likely to see themselves as compliant (12.0%) (Table 7:20).

TABLE 7:20 Subjects' Perceptions of the Admission Process (combined categories) by Education Level

Perceptions of the Admission Process	Education Level 0-9 years	10-13 years	University/ College	Total
Help seeking	16 (45.7%)	14 (35.0%)	13 (52.0%)	43
Compliant	10 (28.6%)	11 (27.5%)	3 (12.0%)	24
Compelled	9 (25.7%)	15 (37.5%)	9 (36.0%)	33
Total	35	40	25	100

$x^2 = 4.011$, df = 4, n.s.

When occupational status is considered, it appears that manual workers (15.3%) more than non-manual workers (4.9%) felt they had been seeking help after others had put pressure on them to do so (b) and also that they had been compelled into the psychiatric admission when they did not consider that they had a problem (e) (11.9%) (Table 7:21). The former may, again, reflect the predominance of male subjects in this category and that males more than females were assigned a 'manual' occupational status. Table 7:21 also shows a slightly higher percentage of non-manual workers felt they had lacked control in decisions about the referral or admission, despite having initially been motivated to seek help (c) (17.1% compared to 11.9%). This too may reflect the greater percentage of females in this category. Non-manual workers were also marginally more likely than others (14.6%) to feel they had been compelled into the admission, although they had recognised that they had a problem (d) (Table 7:21).

TABLE 7:21 Subjects' Perceptions of the Admission Process (all categories) by Occupational Status

Perceptions of the Admission Process	Occupational Status Non-manual	Manual	Total
(a)	8 (19.5%)	11 (18.6%)	19
(b)	2 (4.9%)	9 (15.3%)	11
(c)	7 (17.1%)	7 (11.9%)	14
(d)	6 (14.0%)	5 (8.5%)	11
(e)	3 (7.3%)	7 (11.9%)	10
Parasuicides	10 (24.4%)	13 (22.0%)	23
Out-patient admissions	5 (12.2%)	7 (11.9%)	12
Total	41	59	100

If having resources is related to attitudes towards becoming a psychiatric patient, it might have been expected that manual workers would have been most likely to have felt compelled into the admission and least likely to have seen themselves as help seekers. In fact Table 7:22 shows the opposite.

TABLE 7:22 Subjects' Perceptions of the Admission Process (combined categories) by Occupational Status

Perceptions of the Admission Process	Occupational Status Non-manual	Manual	Total
Help seeking	15 (36.6%)	27 (45.8%)	42
Compliant	11 (26.8%)	14 (23.7%)	25
Compelled	15 (36.6%)	18 (30.5%)	33
Total	41	59	100

$x^2 = 0.849$, df = 2, n.s.

The relationship between whether or not a subject was currently employed and perceptions of the admission process was more consistent with expected findings. As can be seen in Table 7:23, those employed were more likely to see themselves as having sought help both with and without pressure from others (a) 23.5% and (b) 13.7%. They were also more likely than those not employed to feel they had lacked control in decisions regarding the referral and admission, despite having been initially motivated to seek help (c) 17.6%. A smaller proportion of those employed felt they had been compelled into the admission, both recognising and not recognising that they had a problem (d) 9.8% and (e) 3.9% (Table 7:23).

TABLE 7:23 Subjects' Perceptions of the Admission Process (all categories) by Employment Status

Perceptions of the Admission Process	Employment Status: Employed	Not Employed	Total
(a)	12 (23.5%)	7 (14.3%)	19
(b)	7 (13.7%)	4 (8.2%)	11
(c)	9 (17.6%)	5 (10.2%)	14
(d)	5 (9.8%)	6 (12.2%)	11
(e)	2 (3.9%)	8 (16.3%)	10
Parasuicides	11 (21.6%)	12 (24.5%)	23
Out-patient admissions	5 (9.8%)	7 (14.3%)	12
Total	51	49	100

The above findings are reflected in the combined categories when the parasuicides and out-patient admissions are included. Table 7:24 shows that those currently employed (57.0%) more frequently than those not employed (32.6%) saw themselves as help seekers. Those not employed more often saw themselves as having been compelled into the psychiatric admission (42.9%).

TABLE 7:24 Subjects' Perceptions of the Admission Process (combined categories) by Employment Status

Perceptions of the Admission Process	Employment Status: Employed	Not Employed	Total
Help seeking	26 (57.0%)	16 (32.6%)	42
Compliant	13 (25.5%)	12 (24.5%)	25
Compelled	12 (23.5%)	21 (42.9%)	33
Total	51	49	100

$x^2 = 4.837$, df = 2, n.s.

Some subjects, then, appear to have been more likely than others to subscribe to the individual categories. Most of these differences remain when the combined categories are considered. It was seen, however, that those with little psychiatric experience tended to subscribe to category (a) - seeing the process leading to hospitalisation as one in which they had been self-motivated to seek help - and to (e) - feeling as if they had been compelled into the admission and had not recognised that they had a problem. These appeared to be the most extreme categories in terms of individual autonomy concerning the psychiatric admission and attitudes towards this. Lack of psychiatric experience may mean in some cases that problems are not recognised or in others that help is sought immediately.

Manual workers tended also to subscribe to (e) and to (b) - being self-motivated to seek help but after being pressurised by others. Manual workers were predominately males and tended to be in category (b), it was thought because of having alcohol problems which they had initially tried to deal with by themselves.

Subjects who gave more than one explanation for the causes of mental illness - 'multi-category' subjects - tended not to be among those who felt compelled into their psychiatric admission (b) or (e). These subjects in general appear to have advanced views which indicate receptivity to psychiatry.

Subjects who were admitted after a period of out-patient psychiatric treatment tended not to describe the mentally ill in terms of a negative stereotype only. They were perhaps more likely to consider their own condition as 'mental illness' and so not deny the label in this way.

Finally, the parasuicides tended to be under 44 years of age and have less than university or college education.

When the combined categories were considered it appears that those most likely to see themselves as 'help seekers' were Edinburgh subjects, those who described mental illness as a broad range of conditions, males, those with university or college education, those currently employed and to some extent manual workers. In contrast, subjects who felt compelled into the admission were most likely to be Newfoundland subjects, those who described the mentally ill in terms of a negative stereotype only and those not employed. Subjects who were over 45 years of age, married subjects and those with under nine years of schooling tended not to have felt compelled into the admission.

Finally, perceiving oneself as having been compliant in the admission process was described most by females, those over 45, married subjects and those with less than university or college education. However those who described mental illness in terms of a negative stereotype only also described the admission process in this way.

Conclusion

This chapter has considered the subjects' perceptions of the process leading to their psychiatric admissions. The subjects went through a variety of routes before they were admitted to psychiatric institutions. Most passed through all of the four filters and five levels discussed by Goldberg and Huxley (1980). GPs or family doctors apparently played a central role in a large number of cases. In particular, the GP was perceived as a major help source. This is consistent with the literature which indicates that the family doctor plays a major role in recognising psychiatric disorder. Other subjects bypassed the primary care stages by either going directly to the psychiatric hospitals themselves or by being taken there by significant others or the police. Others were referred directly to psychiatric hospitals from other in-patient facilities - in most cases these were parasuicides. A number were admitted to psychiatric facilities after receiving psychiatric out-patient treatment and the process leading to their problem recognition is not known.

The methodology of the present research meant that information on the admission process was only available after the admission had taken place and only a retrospective view of what happened could be considered. Nevertheless this may still be taken to consider the relative applicability of the labelling versus the psychiatric/sick role perspectives to the subjects' admission processes.

Five types of perception of the admission process emerged from these subjects' responses. This was not including the 'parasuicides' and those admitted after a period of psychiatric out-patient treatment. However, all the subjects were considered to be of one of three types - those seeking help, those who felt compliant and those who felt compelled

into the admission.

Only a very small number of the subjects in this research were admitted with a 'compulsory' or 'involuntary' official status. Nevertheless a number were seen to have felt compelled into their psychiatric admissions. It seems more appropriate to consider psychiatric admissions in terms of 'willing' and 'unwilling' patients - a distinction made by Goffman (1961) rather than in terms of official admission status. These particular subjects, then, were 'unwilling'. That there were 33 of these in this sample lends some support to labelling theory. However, the majority may be considered to have been 'willing' patients. This includes both those who described the process leading to the admission as one in which they were seeking help and those who felt compliant in the admission process. While the latter may not have felt 'active' they were 'willing' to be admitted to hospital. Thus a psychiatric/sick role perspective is supported more than a labelling perspective when it came to these subjects' feelings about their psychiatric admissions.

Not all of the 'willing' subjects defined their problems as in need of psychiatric attention before seeking help. However, it seems that individuals first consult their GP or family doctor whom they perceive as an intermediary between themselves and specialised help. It is not necessary for an individual or indeed for significant others to make a decision before this contact about the nature of the problem and the type of specialised help required. The family physician plays the crucial role of gatekeeper to psychiatric services. In this sense, the referral process to psychiatric facilities is no different from that to any other medical facility.

The way these subjects described mental illness and the mentally ill was related to their perceptions of the admission process. Those who described mental illness as a broad range of conditions, and who it was thought were not concerned or anxious about being labelled themselves as mentally ill, were most inclined to have seen themselves as seeking help. They were also least likely to have either felt compliant in the admission process or compelled into this. It was also suggested in Chapter 5 that those who described mental illness as depression only were not anxious themselves about the label of mental illness. However, these subjects were slightly more likely to have felt compelled into their psychiatric admission than to have seen themselves as help seekers or to have felt compliant in the process. Subjects who described the mentally ill in terms of a negative stereotype only, it was suggested, were most concerned about denying mental illness and about becoming psychiatric patients. They most frequently felt compelled into their admissions and least often described themselves as having sought help.

There were differences between the two locations. To some extent this is consistent with the pattern for conceptions of mental illness. Edinburgh subjects were more likely than Newfoundland subjects to see themselves as help seekers (and to have described mental illness as a broad range of conditions) while Newfoundland subjects more often felt compelled into their admissions (and described the mentally ill in terms of a negative stereotype only).

In addition, different types of subject were more inclined than others to describe the admission process in these different ways. These findings to some extent lend support to the argument in Chapter 5 where it was suggested that people with more resources were least anxious about

becoming psychiatric patients. Subjects with university or college education, males, and those currently in employment were most likely to consider themselves as help seekers. In contrast, those who most often felt compelled into their admissions were those not employed, those under 45 and unmarried subjects. However, the argument concerning resources is not wholly supported. Manual workers were also more inclined than non-manual workers to have described the process leading to their psychiatric admission as one in which they were seeking help and those with under nine years of schooling tended not to have felt compelled into the admission.

The other perceptions of the admission process - seeing oneself as compliant - appears to reflect a traditional view of medical practice. This was described most by females, those over 45 years of age and married subjects.

Experience of psychiatry does not appear to have influenced how these subjects saw their admission process. It may be that such experience can result in both positive views and receptivity to psychiatry and negative views and resistance.

CHAPTER 8

Expectations of Hospitalisation and Role Perceptions

This chapter considers the subjects' general expectations both of the psychiatric hospital and the ward milieu and of psychiatric treatment in relation to their impressions and experiences since being admitted to hospital for the first time.

These subjects may have had experience as patients in general hospitals or as psychiatric out-patients even in the hospitals to which they were admitted. However, the subjective experience of becoming a 'psychiatric patient' was new for these subjects. Of primary interest then were the attitudes and expectations from the perspective of people who had never previously been in-patients in a psychiatric hospital.

Several questions pertaining to their expectations and impressions are of interest. Did they have outdated or extreme views of what a psychiatric hospital was? Did they think of the hospital as a traditional 'asylum' with all the concomitant fears which that perspective might imply? Did they expect the hospital to be similar to a general hospital? Did they expect their treatment to consist of medication only, or of some other type of therapy and did they see themselves as active or passive in this? Did they think that their expectations of the hospital or of psychiatric treatment had been influenced in any way by portrayals of psychiatric hospitals, patients, psychiatrists or psychiatric treatment in the media or by their experiences of other people they had known who had either consulted psychiatrists or had been patients in psychiatric hospitals?

They were asked what they had expected the hospital to be like and what their impressions were after having been admitted. Their responses to these questions focussed mainly on the ward milieu and the other patients as well as the hospital in general as it affected them so far. Some subjects more specifically referred to what they ultimately expected to experience or to achieve from being hospitalised, such as the type of help or treatment which they expected to receive or the changes they wished to make in their lives. However, all subjects were also specifically asked what type of treatment they expected to receive, what part they would play in this and what they thought the role of the psychiatrist was. They were also asked what they considered was the role of the nurses, the occupational therapists and the social workers. Additionally, they were asked if they had ever seen films or documentaries, heard radio programmes or read books or articles about psychiatric hospitals, patients or treatment and if they had ever known anyone who had been in a psychiatric hospital or who had consulted a psychiatrist and what they knew about this. Finally, they were asked to consider if either media presentations or direct experience with others had influenced their admission or how they felt about their admission in any way.

Expectations and Impressions of Psychiatric Hospitals

By far the most common expectation conformed to a stereotyped picture of psychiatric patients. Thirty-nine subjects said that in some way their main expectations were that other patients would be 'mad' or floridly or grossly disturbed, exhibiting bizarre, violent or unpredictable behaviour. However, only eight of these 39 said that

what they experienced in hospital concurred with this expectation. Of course, while the crude stereotype of mental illness and of psychiatric patients is not generally reflected in reality, there are some illnesses which manifest themselves in bizarre behaviour and many of these subjects would have experienced such patients on the wards. That these subjects continued to emphasise this as a major aspect of their impressions of life in a psychiatric hospital reflects a strong denial of mental illness and dissociation from other patients. This perspective can be seen in the following description given by a subject of his first impressions and his expectations:

> I sort of expected it like it would be, you know, foolish people going around ... But I don't think it's fair putting me in here, because they could have put me down to the General Hospital... Well I thought it was terrible. I says to the girl downstairs, I don't want to go in here with all these, they were singing and screaming and it sort of unnerved me, you know, the thought of going here.

The rest of those who said they had expected bizarre, violent or unpredictable behaviour on the part of other patients said that once admitted they found either that the other patients were not like this at all or that only some were and generally they were more 'normal' or like themselves than they had anticipated. In contrast to those who continued to make a distinction between themselves and other patients, these subjects, in stressing that others were 'normal' and similar to themselves, may be demonstrating a desire or a need to handle the threatening experience of being defined as a 'mental patient'. For example, one subject said she had anticipated the following:

> A bunch of people crying, shouting and banging things, throwing things around. I expected to go to what they calls a mental hospital.

Contrasting with these expectations are her general impressions:

> Well when I saw the people I realised, I mean I did find it hard coming here at first. I did a bit of crying because I didn't want to come in here because I figured everyone was just gone nuts. And when I got here and saw, and talked to some of the people, I found it quite different. I thought the people would be worse than what they are, really, you know. But they're sensible people, you can sit down and talk to them. I can't see their mental defects if they've got them. Maybe some show a bit of depression, but that's all. It's just the same as you are to talk to.

Thirteen of the 39 said that not only had they expected such stereotyped behaviour from the other patients, but also that the hospital itself would be in some way like a traditional 'asylum'. They frequently referred to the hospital as a 'nuthouse' or a 'looney bin'. Six additional subjects described their expectations of the hospital in this way. Some had expected 'treatments' such as straitjackets or padded cells. Most of these subjects expressed relief on finding that in fact the hospital to which they had been admitted was not at all as they had expected:

> I thought I was coming to a looney place, I did really. I thought that's the end now, I'm going to a place like that. But it's not really, it's not really. Well I wouldn't like to think it's for that. I suppose it's just to give you a sort of rest and rejuvenate you a bit, try to bring you back to your health again, you know. But you always feel I hope people don't think I'm in a looney bin.

Another four subjects were less clear about expecting an 'asylum', but did say that their main expectations were that they would be 'locked up', incarcerated in an institution which was custodial rather than therapeutic or which might resemble a prison in some way.

As was noted above, these subjects generally said that what they found did not coincide with their stereotyped expectations. Only 12 of the entire sample said that in fact their main impression of the hospital centred on stereotyped behaviour on the part of other patients, or that the hospital was in some way like an 'asylum' or that they felt restrained or 'locked up'. It would seem likely that this is a preoccupation of those who felt generally dissatisfied with having been admitted to a psychiatric hospital. It would be expected that these 12 subjects would not only have resisted hospitalisation, but also that they had and would possibly have an unco-operative attitude towards treatment. Of the total sample, 35 were in locked wards, but not all of these stressed this factor.

This seems to indicate that the stereotypes associated with psychiatric hospitals and mental illness are still pervasive among people who have never been admitted to such a hospital previously (with about half of the sample giving such descriptions as their main expectations). It might be expected that similar attitudes and perceptions would also be found among the general public, although perhaps those would be less clearly conceptualised.

The fear and apprehension associated with being admitted to hospital may serve to focus and clarify hitherto vague and unspoken stereotypes. There were a few subjects who described their fears in this way, stressing that these stereotypes were not so much

expectations per se as possibilities giving rise to generalised anxiety. This is illustrated by the following statement:

> Well yes I guess I did (have expectations). I can't even say yes or no there. My inner thoughts were 'Oh God', you know. I could imagine a place with bars on the windows (laughs), padded cells, and whatever. And I was just terrified. Which was totally wrong of course. But my immediate thought when they said Waterford, yes that was it - because I had never seen the inside before - for a few anxious moments. I wasn't sure what it was going to be like. That was my first thought though. It might be the 20th century, but then you never know (laughs).

Certainly the very names of these hospitals, as can be seen in the above example, have certain fearful connotations for these subjects and possibly for the population at large. A response similar to that above was elicited from a subject on being told which hospital in Edinburgh she was being admitted to:

> I just thought it was going to be a horrible place. Just the name, the Andrew Duncan Clinic was enough for me. And whenever he said that I took hysterics.

Informal or voluntary admissions to psychiatric hospitals are relatively recent and it is likely that a '19th century view' of such institutions was the basis for many of these subjects' fears.

Half of the subjects did not say they expected any of the stereotyped images discussed above. Another expectation emerging in subjects' responses was that the hospital would be in some way similar to a general hospital or that the ward would be like a medical ward. Ten subjects said they anticipated this but found it quite different. On the whole, they expressed their surprise in a positive way:

> Well I was surprised. I thought it was a hospital like the Infirmary where you went to bed and a doctor would come and see you and do something for you, you know. I didn't know it was what it was like. I've never been in a place like this before. I didn't know it was just like a house where you just went about and did things on your own. That surprised me.

However, other subjects who had not expected a medical environment were impressed by the similarity of the psychiatric unit or ward to a general medical ward.

Another 11 subjects said they had expected therapeutic units not significantly different from what they had found. That is to say, their expectations were not distorted or extreme in any way. They had all either been admitted from out-patients, had visited friends or relatives in the hospital or had been told by former patients what to expect. Four more subjects, however, entering hospital with expectations based on similar experiences, found the hospital to be different in some ways. In these instances the friends or relatives from whom they had obtained their information, or whom they had visited, had been patients in different psychiatric hospitals. This contrast was stressed in the following example:

> I thought it was quite nice, you know. It wasn't hospitally (sic). Or I don't know how to describe it, because I do know what a mental hospital is like because my father's schizophrenic, so I have been in psychiatric wards, the bad ones.

An additional four, all admitted to hospital because of drug or alcohol-related problems, said they had anticipated being in a detoxification unit or a ward specialising in the treatment of drug or alcohol-related problems. These subjects generally held a negative

view of finding themselves in a mixed acute psychiatric unit. This point was made forcefully by a male subject admitted after an incident involving alcohol:

> Well my expectations were that there'd be nothing but people with an alcohol problem, you see, just being dried out. Because I had a friend who had been in the Andrew Duncan Clinic before Now he was in a completely different place to this ... My first impressions when I came in, I said what kind of place can this possibly be? I saw a girl in a bikini running down the hall and I wondered where on earth I was. Well to me it's not suitable for a detoxification unit with the other patients that are in here. I find some of them very upsetting - a lot of these mental patients and I didn't consider myself mental. I don't consider myself to be in need of psychiatric help to that extent, especially to be mixed up with people like that.

Not all subjects had preconceived notions of what the hospital would be like. Twenty-two subjects said they held no expectations at all. Thirteen of these said that either they did not have adequate time between when an admission was discussed and the actual admission or they had been particularly passive and not in an emotional or even physical state to give this consideration. This occurred more frequently in Newfoundland, partly because of the different admission procedures involved. There, as was discussed in the previous chapter, more subjects were taken directly to the hospital by significant others or by the police. In addition, the parasuicides in Newfoundland were not filtered through a separate treatment facility prior to their psychiatric admission as they were in Edinburgh. The other nine were primarily concerned with obtaining help, the nature of the hospital itself not being a major consideration. This attitude is illustrated in the following:

> Well I didn't know really, I didn't know (what to expect). I didn't have a clue. I heard people who came here and they're saying that the condition I was in - and they got help here - and I figured this would be the best place to get help.

These expectations are summarised in Table 8:1. Although a number of the subjects mentioned more than one expectation, they are coded here by the first or major view expressed.

TABLE 8:1 Subjects' Expectations of the Hospital Environment

Expectations	No. of subjects
Other patients as bizarre, disturbed/ hospital as stereotyped asylum	45
Custodial environment	4
Like a general hospital/medical ward	10
Therapeutic environment	15
Detoxification unit	4
No expectations	22
Total	100

Other associated anxieties were mentioned with regard to the experience of being hospitalised. Twenty-two subjects said they had been anxious because of the stigma of being a patient in a psychiatric hospital and/or because of the general stigma attached to mental illness. Another eleven said they were generally apprehensive, mainly because of a fear of the unknown. This reflects a number of worries: a fear of what would happen to them and how they would be treated in hospital, a fear of adopting the status of 'psychiatric patient' or of being labelled as 'mentally ill', and a fear of their illness itself as an unknown factor. One subject said:

> But I was apprehensive about coming into a mental hospital, a little less so after she showed me around the ward ... I felt very anxious coming here because, I suppose, of the stigma attached to mental illness and a kind of fear of my own illness.

The majority of the subjects, however, described their overall impressions of the hospitals to which they had been admitted in positive terms. Eighteen said the hospital or their particular ward was like a hotel, a boarding house or was simply like being at home. Four subjects specifically stated that being in hospital was similar to being on holiday. Another two said it was like living with a 'large family'. Single individuals likened it to a 'hostel', 'a boarding school', 'a nursing home' and a 'convalescent home'.

Ten subjects expressed the view that in some ways the hospital was similar to a general, medical hospital and were generally positive in this appraisal. These contrast with those subjects who expressed relief at finding it unlike a general medical facility and who made favourable comments about the lack of discipline. That the hospital was perceived in this way might be thought surprising considering that all of these units were at least nominally or minimally run along the lines of a therapeutic community. It is likely that different wards or units and different individual staff members varied in terms of discipline and authoritarianism. In addition, people undoubtedly vary in terms of tolerance of a disciplined order as opposed to an open regime. These differences in perceptions and attitudes will be discussed in greater detail below.

The major impressions of the hospitals or units are noted in Table 8:2. These are not totalled as not all subjects responded to

this question in a way which would allow them to be included here. Many, for example, when asked about their impressions gave other types of appraisals of the hospital or ward environment - both positive and negative. The appraisals are noted in Table 8:3.

TABLE 8:2 Subjects' Impressions of the Hospital Environment

Impressions	No. of subjects
Other patients bizarre, disturbed/ hospital as stereotyped asylum	12
Like a hotel/boarding house/home	18
Like a hostel/boarding school/ nursing home/convalescent home	4
Like living with a large family	2
Like being on holiday	4
Like a general hospital/medical ward	10

Other positive features of the hospitals were that they were 'pleasant' or 'warm'; 'relaxed'; that they liked the lack of discipline normally associated with hospitals; that it was 'friendly'; that they were pleased at the amount of freedom, activity or independence which they were allowed, and that they had more privacy than they had anticipated.

One impression of being in hospital, mentioned by 13 subjects, was that it was 'boring'. However, although a criticism, this was not necessarily linked with a generally critical or negative perspective. Some who mentioned this held generally favourable and positive views of their hospitals.

Critical or negative comments were that they felt restrained or confined; that the atmosphere on the ward was tense or depressing; that the lack of discipline was associated with lack of organisation and even disorganisation, or that there was too little privacy.

Twenty-four subjects expressed the view that either they were displeased at having been inappropriately placed in a particular ward with patients whom they perceived as dissimilar to themselves or that they were generally anxious about the proximity of those other patients. For many, however, this was not their overriding impression of hospital life.

The subjects' appraisals - both positive and negative - and the numbers mentioning each are noted in Table 8:3. Again these are not totalled. Many subjects gave more than one of these responses.

TABLE 8:3 Subjects' Appraisals of the Hospitals/Wards/Units

Positive Appraisals	No. of subjects
Staff - pleasant, warm	17
Relaxed atmosphere	16
Lack of discipline	8
Friendly atmosphere	8
Freedom/activity/independence	7
Privacy	5
Criticisms	
Felt inappropriately placed/anxious about proximity of other patients	24
Boring/lack of activity	13
Restrained	13
Lack of privacy	4
Lack of discipline/organisation	2
Tense/depressing atmosphere	5

Subjects' overall impressions of the hospitals to which they had been admitted were predominantly positive. Altogether only ten described the hospital in an almost totally negative and critical way. They stressed that they disliked being there, that they did not think that they needed treatment, and that they were trying to arrange a discharge. There were others who were critical and negative but

appeared to have accepted for the meantime their admission and a need for some type of treatment and were generally compliant.

Stereotypes, the Media and Psychiatry

It is of interest that so many subjects in this research said they had expected bizarre, violent or unpredictable behaviour on the part of other patients in the ward or an 'asylum' with features such as barred windows or padded cells. Where these stereotypes originate and how people come to perceive the world of the mentally ill in these terms needs to be considered.

It may not be surprising that at least some subjects expected the hospitals to resemble 'asylums'. Many hospitals were built in the 19th century with a view to a custodial rather than a therapeutic function and are probably not only known in their surrounding communities as 'looney bins' or 'nuthouses', but they also continue somewhat to resemble their former selves at least in external appearances. Few new hospitals have been built and modern developments tend to be within existing hospitals or as additions to them. However, although there have been many changes and improvements to these buildings, it is obviously not merely the structure that influences attitudes. Many prestigeous general hospitals are as old and have only been modernised in similar ways but are not feared or stigmatised in the same way.

Prior to the development of a variety of psychotropic drugs in the 1950s - particularly the major tranquillisers - some patients did behave in ways similar to those stereotypes described by these subjects. There were more patients on the wards but fewer were quietened by

sedatives and other practices of restraint were also employed. The emphasis was on firmly locked wards and straitjackets and padded cells had not been entirely phased out. But even prior to this period, not all patients would have been like this.

Why do these stereotypes persist? As was discussed in Chapter 2, the formative and still influential literature on attitudes towards mental illness and the mentally ill suggests that a stereotypical image of the mentally ill is presented in the media (cf. Nunnally, 1961; Scheff, 1963 and 1966). Recent evidence suggests that although stereotyped images are presented in some media, others present more realistic portrayals (Winick, 1982).

To address the question of media influence directly, these subjects were asked if they had seen TV programmes, films, documentaries, heard radio programmes, read books or magazine articles, or had discussions with others about mental illness, the mentally ill, psychiatric hospitals or psychiatry in general, and if they thought it had affected their expectations in terms of giving them a picture of what life in a psychiatric hospital would be like and if it had affected their decision to enter hospital.

It was expected that these subjects would be familiar at least with a variety of films on the topic, given the number which have been produced over the years, and that this might have directly influenced their attitudes. However, only a minority could recall having seen such a film and in most cases their recollection was vague and focussed on a particular aspect of behaviour in a specific scene or location or on a well-known actor or actress.

Of the films which these subjects did in fact mention in response

to this question, One Flew Over the Cuckoo's Nest was the most frequently cited and also the most influential in terms of expectations of a psychiatric hospital. Others mentioned were Psycho and Lost Weekend. The classic portrayal of a psychiatric hospital - The Snake Pit - was recalled by only one subject. It may be that some other subjects would have seen this at some time in the past but, given that it was first released in 1948, regarded it as almost historical and therefore irrelevant to the topic under discussion.

American situation comedies such as Rhoda and Soap were also specifically mentioned with reference to a portrayal of the psychiatrist in the media. Very few subjects in the entire sample recalled having read anything on mental illness or psychiatry other than a few university students who said that they had read such material while taking courses. As the question specifically stated magazine or newspaper articles as possible sources of this type of information, this lack of response is particularly curious. It is almost impossible to find any general magazine, particularly women's magazines, which do not contain such articles on a regular basis - a point also made by Winick (1982:227).

On the whole, what these subjects did recall on this topic was highly stereotypical. They tended to mention portrayals of violent or bizarre patients, behaviour such as screaming, self-mutilation or assault, or scenes featuring padded cells, barred windows and straitjackets. Others, however, mentioned portrayals of patients suffering from milder forms of illness or treatments such as hypnosis or group therapy.

When asked if their recollections from the media had influenced

their expectations of the hospital or their decision to enter the hospital, many said with reference to One Flew Over the Cuckoo's Nest and other films that they thought the situation presented was historically too distant for hospitals or patients to be similar now. The following quotation represents this type of response:

> I suppose it (One Flew Over the Cuckoo's Nest) was made some time ago and attitudes and conditions in psychiatric hospitals have changed. I suppose that the aim of a lot of television programmes like that is to inform people, you know, the usual documentaries, and therefore they are up to date, they're usually quite good. But some of them, the older films and things like One Flew Over the Cuckoo's Nest just give a really distorted picture. People don't understand that all of that was say 10, 15 years ago.

In fact One Flew Over the Cuckoo's Nest was released in 1975, only four years prior to this interview. However Kesey's novel was published in 1962 - one year after Goffman's Asylums - and the film tends to reflect conditions in American State hospitals at that time. The nature of such institutions was brought to public attention, and this coincided with, among other things, the 'anti-psychiatry' movement. Winick (1982:229) points out that the novel "Contributed to the decade's unique ideology and political atmosphere". During the same period of time interest in deinstitutionalisation and community care was developing. The film itself was extremely popular and reached a mass audience - people who might never have otherwise been aware of issues surrounding the treatment of the mentally ill. Despite this, these subjects did not appear to have consciously based their expectations on this or any other film.

Most of such films were American and portrayed psychiatric hospitals in the United States. The system of 'State Hospitals' and other types

of institutions was and is quite different from the system in the UK and even in Canada and these subjects may have made this distinction. Some subjects in fact explicitly expressed the view that because portrayals in the media were American they were not to be considered as possibly resembling the situation in which they found themselves.

Alternatively, the 'fictional' aspect of such films was stressed by some. One subject, for example, likened it to reading 'fairy stories', saying it no more struck him as having any bearing on reality than reading 'Cinderella' would.

The distinction between 'fiction' and 'fact' emerged quite distinctly from these subjects' opinions on this topic and was further highlighted by several subjects who emphasised that all they could recollect seeing were documentaries or 'exposes' based on investigative journalism. In particular, a significant number of subjects in Edinburgh said they had seen one on Rampton Hospital which had been screened on television earlier that year. This tendency to distinguish between 'fact' and 'fiction' was also noted by Nunnally (1961:76).

It seems most likely that the stereotypes associated with mental illness presented in the media are not directly associated on a conscious level with people's personal situations unless they are seen as applicable at that time. This view is expressed in the following response to the question of whether the subject had gained an impression of what the hospital would be like from having seen One Flew Over the Cuckoo's Nest:

> Do you know I never put the two together until you just mentioned it. But maybe that's where it (her fear of the hospital) came from, because I've never known anyone who's been in here before, and maybe that's where that impression came from.

Similarly, most subjects who said they could not recall ever having seen, heard, read or discussed anything on the topic stressed that it was just not a subject in which they had had any interest, never having thought that it would be relevant personally.

There were, however, several subjects who said that the views they had received from media presentations had adversely influenced their expectations and had caused them some anxiety but they tended to stress that relief from their problems was the most important consideration. It may be that other subjects had felt similarly prior to their admission but had since forgotten about such fears.

Certainly these stereotypes appear to persist, but given the evidence here, people do not generally seem to associate on a conscious level what is presented in the media and reality. It may be, as Scheff (1966) suggests, that the media simply reinforces stereotypes which already exist. Such a view can be seen in this response from a subject who was asked if what he had seen in the media had affected his decision to admit himself to hospital:

> Yes I'm sure it has in part. I didn't really want to come. Because I'm sure over a period of time, although you're not conscious of the build up of a picture, a mental picture, just through information you receive, whether it's visual or verbal, and it may not necessarily be something you're considering at the time, that you're not necessarily trying to assess at the time. But I mean the information is stored. Perhaps because you haven't assessed it, it does sort of pile on top of each other and create this skewed picture which is not very helpful.

Winick (1982), as was mentioned above, suggests that more recent presentations in the media have been less stereotyped and more realistic, particularly differentiating between films made prior to and after 1968. Perhaps in part this change accounts for the lack of stereotyping among a number of subjects in this research.

The Psychiatric Patient and the Sick Role

As was discussed in Chapter 2, the applicability to psychiatry of the sick role as formulated by Parsons (1951) has been questioned. Activity and self-direction on the part of the patient may frequently be the major expectations of the psychiatric patient role. (1)

As these subjects had never previously been in-patients in a psychiatric unit, it might be expected that they would have little understanding of the psychiatric patient role or of the aims and methods of psychiatric treatment and that their role perceptions and expectations of treatment would be based on their knowledge and experience of the medical sick role and treatment in general medicine. The fact that most subjects said they were impressed that the psychiatric wards or units were different from medical wards does not mean that they fully understood how a psychiatric ward functioned or

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(1) Of course it may be that the expectations associated with the sick role in many branches of medicine also include the desirability of some active participation on the part of patients. Psychiatry, in practice, may not be entirely different from general medicine

that they considered that the psychiatric patient role was in any way different from that in general medical practice.

However, these subjects appear to have assimilated some information about the nature of psychiatry and psychiatric treatment, despite having only been in hospital for a short time. On arrival at the ward when first admitted, these subjects were generally told basic details of the ward's day to day functioning. Not all subjects said they had found out such information in this way. Some said they knew of the routine because it was posted somewhere in the ward or that other patients had told them about it. Others said they simply followed other patients to meals, meetings and to collect medication.

More detailed information on these psychiatric wards appears to have been disseminated in a number of ways. Some subjects said they had been told some aspects of their treatment goals directly by nurses or in consultation with psychiatrists. Some said they had learned something of psychiatry or psychiatric treatment from other patients. Most information about treatment, other than medication, appears to have been gained at group therapy meetings. However, as was mentioned in Chapter 3, the methods of the therapeutic community appear to have been made more explicit (and were more strictly adhered to) in the Professorial Units in the Royal Edinburgh Hospital and in the Health Sciences Psychiatric Unit than in the Royal Edinburgh Hospital 'sector wards' or the Waterford Hospital. Subjects in the former, despite having been patients for only a short period of time, might be expected to have a greater understanding of psychiatry and the role of the psychiatric patient than subjects in the latter.

Other factors, such as experience as out-patients or of friends or

relatives who had been psychiatric patients, might also be likely factors influencing these subjects' role perceptions and expectations of treatment.

In addition, the extent to which these subjects assimilated information might have been influenced by their condition when admitted. Subjects admitted in extremely distressed conditions might also have been less likely to absorb such facts because of their condition.

Having knowledge about the psychiatric sick role and about psychiatric treatment does not necessarily mean acceptance of such. Even where patients may have been explicitly told about their treatment goals and the behaviour expected of them, it is still possible that they could continue to perceive their patient role as passive and expect to be treated as if they were in a general medical ward. It seems likely that not only would the methods of the therapeutic community need to be made explicit to the first admission patient, but also that they would have to be convinced of its appropriateness. That is they would need to be 'educated' into accepting and adopting the psychiatric sick role. A strong preference for a passive patient role, or initial resistance to hospitalisation, may inhibit such receptiveness.

Subjects' Perceptions of the Patient Role and the Ward Milieu

To explore the problem of what people expect when entering a psychiatric hospital for the first time, these subjects were asked several questions to investigate their perceptions of their own role as patient, their role vis-a-vis the psychiatrist, the nursing and other

ward staff, of the generalised staff role and their perceptions and expectations of treatment.

There were four major categories of subjects' role perceptions based on an active versus a passive patient role and a 'democratic' and psychotherapeutic ward milieu versus one perceived as hierarchical and/or paternalistic with a major emphasis on physical treatment. Their perceptions of the ward milieu incorporates their understanding of the psychiatric staffs' roles. As was seen in Chapter 2, other researchers have made similar contrasts when considering treatment modes and staff roles (cf. Gilbert and Levinson, 1957; Scheff, 1960; Rubenstein and Lasswell, 1966).

Following these perspectives, the term 'democratic' is used in this research as the basis of a view described by these subjects where the ward milieu was perceived as being based along the lines of the therapeutic community; where patients were thought of as interacting with staff on a more or less equal basis in the treatment situation; where psychiatric staff were not seen as giving orders to be followed by the patient. The 'democratic' ward milieu contrasts with one which was perceived as authoritarian and hierarchical; where the patient was given treatment as opposed to participating in it.

Of course in this research we do not know how the staff themselves perceived their own roles - only what the subjects considered them to be. However, it is this which is of major interest in gaining an understanding of what patients expect from being admitted to a psychiatric hospital and how they perceive what they find. This in turn may be important in influencing the effectiveness of the therapeutic situation. As Skodol et al (1980:73) argue:

Non-complementary expectations concerning both the goals and the methods are particularly disruptive to the establishment of a working alliance early in therapy.

A few subjects did not appear to fully understand the treatment situation and these are discussed separately. The subjects are considered in these categories on the basis that, however reluctantly, they had accepted that they would receive psychiatric treatment. Those opposed to receiving treatment and wishing to discharge themselves are also considered separately.

The following categories emerged from the subjects' responses:

(a) Subjects who saw their role in their own treatment as active and who considered that the ward milieu was based on dynamic, psychotherapeutic treatment and a democratic sharing of responsibilities;

(b) Subjects who saw their role in their own treatment as passive and who considered that the ward milieu was based on dynamic, psychotherapeutic treatment and a democratic sharing of responsibilities;

(c) Subjects who saw their role in their own treatment as active and who considered that the ward milieu was hierarchical and/or paternalistic with a major emphasis on physical treatment;

(d) Subjects who saw their role in their own treatment as passive and who considered that the ward milieu was hierarchical and/or paternalistic with a major emphasis on physical treatment.

In addition there were:

(e) Subjects who generally perceived that they were in a situation that they did not fully comprehend; where they saw themselves as passive but had not formulated a clear picture of their own or others' roles in the treatment situation.

All of the subjects in these categories implied that, whether or not they were pleased or relieved at being in hospital, they were willing to remain in hospital and receive treatment, at least for a while. In contrast, there were:

(f) Subjects who said they felt they did not need treatment or further treatment, who did not wish to remain in hospital and who were planning to arrange their discharge.

(a) Subjects who Perceived their Role as Active and the Ward Milieu as Democratic and Psychotherapeutic

These subjects perceived their patient role in treatment as active and the ward milieu as based on dynamic, psychotherapeutic treatment and a democratic sharing of responsibility. They felt that active self-participation was an integral and necessary part of their own treatment and their main orientation was to co-operate on a democratic basis with the staff in order to deal with their particular problem. Nurses, occupational therapists and social workers were perceived as part of a 'team effort' in treatment. They tended to accept the methods of the 'therapeutic community', also tending to see themselves as playing some part in co-operating in the therapy of other patients. There were 21 such subjects.

The 'active' role of the patient can be seen in the following response relating to a question on the perceived purpose of the unit:

> To help people to help themselves. I mean they're going to show me hopefully or perhaps point out to me a direction that I've maybe overlooked, and I'll be able to work it out. It's all going to have to come from me, I know, well most of it. They're only catalysts and that includes both patients and staff. I mean it's going to have to come from me. So I think the main aim of it is a catalyst.

These subjects, as part of this perception, tended to consider group therapy as a major part of their treatment and generally emphasised the importance of psychotherapy as opposed to medication or physical care. For example, one subject, when asked what type of treatment she expected to receive while in hospital, replied:

> Therapy, I think, just the therapy helps you - occupational and the group therapy and discussions with Dr ... I had one with him yesterday and he said that's what I'm going to be getting once a week, and a ward round with Professor ... I expect we'll have a lot of talks over and above the group therapy. And the occupational therapy. I don't know if I'll get any drugs, I'm not sure. I'm only given amitryptilin but I'm not expecting anything else.

And when asked if there was any other treatment she might like to receive she said:

> No, other than talking to someone. I feel now that when I talk with someone, someone who's experienced in psychiatry, they can understand, put a meaning to it. Because it's all just words to me. But obviously somewhere, there's a deep-rooted thing somewhere, I think.

The subjects in this category also tended not to have a simple view that a 'cure' would be forthcoming, and certainly by definition did not think that such a 'cure' would be administered by an omnipotent psychiatrist. The role of the psychiatrist in relation to treatment was described by one subject as follows:

> Well I suppose just to help people resolve with their problems and get themselves straightened out. And if you can't solve it one way then you can another. I don't think they're, oh my God they're not miracle workers. You have to help yourself and if they're not getting any of that there's not much they can do, is there?

The aim of 'treatment' for most of these subjects was to achieve some basic change in personality or in some aspect of their social functioning; they were highly motivated towards this and they did not see the short-term alleviation of symptoms as an end in itself. For example, one subject described her role in treatment as:

> I think really try and think a lot better, try and organize myself better than what I'm able to do just now, and maybe make my own decisions. So I think I'm going to try and sort out, get my head together. And once I get over that - making decisions for myself - everything should come quite easy. I hope it does anyway.

These subjects, compared to others in this research, tended to be more knowledgeable about other people's problems - most likely because of their active interest in group therapy - and they did not generally distance or dissociate themselves from other patients. They also tended to be fairly optimistic about the beneficial effects that hospitalisation and psychiatric treatment would have for them, although not unrealistically so. Of course, these factors may have been partly influenced by their psychological state. Had they been extremely depressed they might not have been as optimistic. Such perceived role congruence tended to result in satisfaction and a lack of negative attitudes towards hospitalisation.

Given the nature of the research it is impossible to know just who had such a perspective of psychiatry prior to entering the hospital and who had developed these ideas since. Four said they had specifically been told what to expect by other people they knew or they had had experience of visiting relatives or friends in a psychiatric hospital, but this was not unusual among this sample.

It seems likely, however, that a number had come to accept this perspective since being admitted - that is the methods of the therapeutic community had not only been made explicit to them but they had also been convinced of its appropriateness. Ten of the 21 in fact said that they had been somewhat reluctant to admit themselves to hospital or were anxious about this because they had expected either that other patients would be violent or would behave in a bizarre fashion or that the hospital itself would be like an 'asylum' of the type described above.

The influence of the ward environment in 'educating' these subjects into an acceptance of the methods of the therapeutic community may account partly for these subjects' perspectives. As was discussed above, the methods of the therapeutic community appear to have been more consciously applied in the Professorial Units than in the 'sector' wards at the Royal Edinburgh Hospital. Of the seven subjects in the entire sample from the Professorial Unit, Ward 1, six were in this category. Another four in this category were patients in the Professorial Unit, Ward 2. (2) Only two of the 15 Edinburgh subjects in this category were patients in 'sector' wards. The impact of the regime in the unit itself for the Newfoundland subjects is more difficult to interpret as there were three subjects in this category from both Waterford Hospital and from the Health Sciences Psychiatric Unit. As was also discussed above, the methods of the therapeutic community were more consciously applied in the latter.

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(2) It may be that people entering the Professorial Units are selected to some extent and this may account partly for the fact that so many subjects in this category are patients in these Units

In addition, however, it seems likely these subjects were less resistant to hospitalisation than subjects in the other categories. This will be discussed below.

It seems likely then that many of the subjects in this category had undergone an 'educational process' - that is the methods of the therapeutic community had been made explicit to them and they had accepted these as appropriate. They may have entered the hospital with a different attitude: that their patient role would be based on behaviours expected in the medical sick role; that it would not be necessary for them to participate actively in their treatment; that theirs and their psychiatrists' respective roles would be passive and authoritarian, and that a 'cure' might be effected. Some ambivalence, in fact, might be expected, and this and the negotiation and 'education' which likely had taken place is reflected in the following quotation:

> I wanted someone to tell me things and that's not going to happen, I think. I'm going to be made to realise and ask and ask and ask. Well no, I get told, I get told in the group meetings. But I don't mean telling me 'You do this because of that', telling me 'You're a something or other'. I mean telling me, 'Right, this is what you've got to do <u>now</u> to be better', you know. I wanted instructions and that's not really what I'm going to get.

Such changes in attitude were not always forthcoming. Not all subjects accepted the methods of the therapeutic community as appropriate or desirable, despite being aware that this was the basis of the ward treatment structure. This perspective is reflected in the second category of subjects.

(b) Subjects who Perceived their Role as Passive and the Ward Milieu as Democratic and Psychotherapeutic

There were 17 subjects who perceived their own role as passive but who perceived that the ward milieu was based on dynamic psychotherapeutic treatment and a democratic sharing of responsibility. These subjects tended to want their psychiatrists to administer something to effect a 'cure' for their problem - usually, but not always, medication, or at least wanted treatment based on recognisable 'medical' methods, such as physical examinations. Having found that they were expected to become part of the therapeutic process they generally expressed dissatisfaction, or at least confusion, arising from role incongruence. They did not, on the whole, express a desire to be involved in the other patients' therapy, and had expected the nursing staff to be either custodial or involved in the traditional role of the nurse, in duties which involved carrying out the orders of the medical staff, in administering medication, and in physical care.

This perspective, from the point of view of people with no prior experience of routine and process in a psychiatric hospital, is understandable. It is a view based on experience and knowledge of the patient role in physical medicine, one which these subjects would likely have some understanding or experience of. The perceived role incongruence leading to dissatisfaction or confusion is to be expected where the medical sick role, as perceived in this way, confronts and conflicts with a democratic and dynamic therapeutic approach in psychiatry. The confusion over the treatment available is reflected in the following statement:

> As far as I can gather at the moment they're just treating me like an ordinary person. I mean there doesn't seem to be any treatment at all attached to it. I mean they're not drugging you in any way or anything like that.

A similar view was expressed by another subject in this category:

> I said 'Well what am I doing here?' I says, 'I'm under no sedation'. He (the psychiatrist) said 'Well we just think you need rest and just take rest while you have it with having the baby'. So I didn't know, but they still never said when I was going and I keep asking them and they'll not answer anything because they laugh at you. I think they don't know themselves, they're not sure what to do with me, because I'm no daft, I'm no stupid and I'm no an alcoholic. So I don't know what they're trying to work out. Maybe I'm something in between.

This subject was obviously ambivalent about her role as psychiatric patient, stressing that the other patients, for the most part, were quite different from herself and quite ill. However, although denying the term 'mental illness' as applicable to herself, and in fact not being sure if she should be in a psychiatric hospital, she repeatedly stressed her desire both for a 'rest' or for someone to 'take care' of her, as well as for medication and physical examinations. It is possible, as was mentioned in the first category, that the admission process itself either has some influence on, or reflects the likelihood of, the acceptance of a viable psychiatric patient role. This subject, for example, had been admitted after some action on the part of a neighbour, and this obviously affected how she felt about the admission, about being defined as a patient and, indeed, about being treated in a psychiatric hospital.

The subjects in this category tended to be dissatisfied with the

arrangements for group therapy such as the frequency of and the stress placed on the importance of these meetings. This is expressed in the following statement:

> There's a wee bit too much group therapy for the state of my mind at the moment. I suppose I have to remember they're doing it for a treatment.

They also tended to be dissatisfied with the lack of directives in general ward life.

> I am left with the feeling of psychiatry, it always seems to, to just stop. Patient heal thyself. I think that's what they aim at. I don't think that works.

These subjects appear to have entered the hospital with a view of the patient role and the treatment they might receive similar to that which might be expected on a medical ward, but unlike those subjects in category (a) who had apparently accommodated their views to fit with the ward's therapeutic definition, they continued to hold perspectives of non-complementary roles and relationships in the treatment situation. The following quotation is similar to that of the subject in category (a) who had entered the hospital hoping to passively receive some 'cure', but who had since adopted the prescribed active role and who had accepted her share in the responsibility for her own treatment. Unlike the first subjects, this one continued to express some dissatisfaction and disappointment at the realisation that an instant cure would not be forthcoming:

> I mean I thought maybe I would get, something would be done, maybe an injection or something to jolt me out of this. That's what I thought but it's not going to be like that at all... I thought if it was in the mind that something would be done to jolt me back to myself again. I would love for something to happen to get me back to myself.

Her rejection of an active role in her own treatment, which of course may reflect her depression, is seen in her response to a question on whether the psychiatrist would want her to do anything in relation to her treatment. She replied:

> Well I've tried to help myself. The doctor told me to try and pull myself together and I've tried and I haven't been successful.

This category is of interest, in that with two exceptions the subjects had been admitted because of problems other than drugs or alcohol. Indeed, four of the 17 manifested specifically somatic symptoms and for these four in particular it is not surprising that they were confused by what they perceived as role incongruence. Although they were generally accepting of the idea that there might be a psychological basis to these problems, they were concerned primarily with the immediate reflief of symptoms.

What is surprising about the subjects in this category is the number who had either received out-patient treatment in the past, of which there were six, and those who were admitted to hospital after a period of consultation as out-patients, of which there were an additional four. It might have been expected that subjects with such experience would have adapted to psychiatric treatment on an in-patient basis and would have adopted a more active role. It may be that, being accustomed to

only one-to-one consultations with psychiatrists their experience of treatment only really consisted of individual therapy and medication, and had not prepared them for a democratically structured ward milieu. They may have continued to define their patient role as out-patient in terms of the traditional doctor-patient relationship and wished to extend this to their in-patient experience.

All but three of these subjects were patients in 'sector' wards where, as was mentioned above, the 'therapeutic community' was less strictly adhered to. Unlike those in category (a), these subjects did not appear to have been influenced by the ward environment into accepting the psychiatric patient role and the appropriateness of the methods of the therapeutic community.

(c) Subjects who Perceived their Role as Active and the Ward Milieu as Authoritarian with a Major Emphasis on Physical Treatment

A third group of subjects perceived their patient role as active, or at least potentially so, and considered that active participation on their part was integral to their treatment. However, they simultaneously perceived the ward milieu as non-democratic, authoritarian and possibly paternalistic with a major emphasis on physical treatment. As in category (b), with perceived role incongruence between staff and patient, there was a tendency to dissatisfaction, or at least confusion, although not in all cases.

The following description of the treatment he was receiving was given by one subject who felt he wanted to be active in his own treatment, but was critical of the fact that all he seemed to be receiving was medication:

> Treatment, I don't know what they're giving me. Someone gives me a glass of water, and gives me my pills. The nurses say 'hold out your hand' and I drink the water. I'm given a couple of pills, all right, and as soon as the pills wear off again, it's the same thing again.

The perspective characterising this category seems to have developed when subjects had expected types of therapeutic milieus different from those found on the wards to which they had been admitted, or where they held strongly preconceived notions of the treatment they would and should receive. This did not apply only to this group of subjects. However it may be understood by considering the nature of the problems which had given rise to their admissions. Of the 12 subjects in this category (ten male and two female), eight had been admitted because of problems relating to alcohol and another two because of heroin addiction, the only two such subjects in the sample.

It is perhaps not surprising that a majority of subjects in this category had problems relating to substance abuse. In contrast to the treatment of the 'mentally ill' patient, the dimension of self-help relating to the treatment of drinking problems is probably more widely acknowledged and publicised, and these subjects were probably aware of this prior to entering hospital. Even if this were not so, the general responses of these subjects make it clear that patients admitted to the hospitals because of problems with substance abuse are quite specifically told that they will be expected to play an active part in dealing with their own problems. This perspective is illustrated by the following response of a subject to a question on the type of treatment he expected to receive:

> Well to me, there's no treatment can help me. I can only help myself. And that's what I would say to anyone else, for alcoholism. I mean there's nobody can do it. They can give you all the pills under the sun, yes, stop you shaking, but you're still back to you.

That all of the subjects in this research admitted to hospital because of such problems did not perceive their role in this way is perhaps surprising, given the above explanation. A great deal of this diversity and ambivalence may be reflective of the historical position of psychiatry vis-a-vis alcoholism and drug dependence. Alcoholism and drug dependence are included in the WHO's (1978) classification of mental disorders and the trend has been towards defining such problems as diseases (Mechanic, 1978:51). However, there remains some debate, as with all psychiatric disorders, as to appropriate treatment. It is likely that other subjects, who perceived their patient role as passive, in defining themselves or being defined as 'ill', had considered that the medical sick role was appropriate to their situation. It is also likely that they wished to be passive, to receive a 'cure' and to be exonerated from moral judgements associated with their problem.

Three subjects in this category were involved, or had been involved, with Alcoholics Anonymous, had adopted the philosophy of this group, (3) which had familiarised them with the idea of 'self-help'. This they had apparently incorporated into their perceived patient role. This experience seemed also to have prepared them to understand the value of the therapeutic group. For example, one of these subjects explained

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(3) The philosophy of Alcoholics Anonymous is not identical to that of psychiatry but certain aspects, such as that described above, are similar

his knowledge of group therapy as follows:

> It's a crowd of patients with the same problems to talk. They talk and try to talk their similar problems over and help each other in that way. By the way I know that I was a member of the AA for eight months of this year and that's what I would call group therapy.

Six of the other seven subjects with substance abuse problems in this category had friends or relatives who had been hospitalised for similar problems, and had discussed such problems and hospitalisation. Because of what they had been told, three of these subjects specifically said they had expected to be admitted to a 'detoxification unit' and not a general psychiatric ward. These three, and three others in this category, expressed either anxiety about or dissatisfaction with, being on the same ward as patients suffering from other conditions. This in itself appears to have been a focus for criticism. This view can be seen in the following response:

> One friend has been in the detoxification unit, the ADC. Now I didn't see him but somebody went to see him and told me that he was, I think, he was in a ward on his own, with television and everything in the ward. And he'd been, I think he was in for several weeks, and that was my idea again of what a book told me. Detoxification unit would be where I would be by myself, not mixed up with a crowd of, like this.

The two subjects in this category admitted because of problems other than substance abuse were simply emphasising their dissatisfaction with what they perceived as a lack of active psychiatric treatment in the ward. They wanted to be actively involved but felt that the main treatment given consisted of medication and physical care

and was inadequate to deal with their problems. They were critical of the lack of contact with the psychiatrists, whose activity they considered did not go much further than prescribing medication and giving orders for the nursing staff to carry out.

Despite all of these criticisms the subjects in this category were willing to remain in hospital to receive treatment, at least for a while. Despite perceived role incongruence, dissatisfaction was not necessarily felt in all cases. It seemed possible for some subjects to continue to perceive their role as active in treatment with the psychiatric staff perceived of as playing only a peripheral role by administering basic care, physical examinations and tests, and medication. Perceived role incongruence did not always lead to dissatisfaction in cases where these subjects did not see dynamic therapeutic activity by the psychiatric staff as necessary.

The factors influencing the perceptions of subjects in this category appear to be strongly preconceived notions of expected treatment, particularly for problems with substance abuse, experience in Alcoholics Anonymous, and most importantly, experience of others who had been in hospital and received treatment for substance abuse problems.

These subjects defined their own patient role in a similar way to those in the first category and it seems likely that they might also have held similar perceptions of the therapeutic milieu if in fact they had been patients in wards where the methods of the therapeutic community were intensively followed. Again, the type of ward or unit seems to have played a part in influencing role perceptions. All of the Edinburgh subjects in this category were in 'sector' wards and all

of the Newfoundland subjects were in Waterford Hospital. As was mentioned above, the model of the therapeutic community seemed less strictly applied in these wards than in the Professorial Units in the Royal Edinburgh Hospital and the Health Sciences Psychiatric Unit in Newfoundland.

Of the subjects in this category who had been admitted to hospital after what they considered to be coercive action by significant others, only one appeared to be dissatisfied because of this. This particular subject argued that had he arrived at the hospital by another route he might have been admitted to the Unit for the Treatment of Alcoholism, which would have been his preference.

(d) Subjects who Perceived their Role as Passive and the Ward Milieu as Authoritarian with a Major Emphasis on Physical Treatment

A fourth, and large, category consisted of 35 subjects who saw their own role as largely passive and the ward milieu as authoritarian and/or paternalistic with a major emphasis on physical treatment. The resultant perceived role congruence between staff and patient tended to result in satisfaction with a few exceptions. A sub-category of this group were those who said they did not like being in hospital but who felt passive and powerless because of the fact of having been hospitalised. They implied that they had accepted the psychiatrists' authority and were willing to accept treatment, at least for the immediate future. They saw their own role in treatment as accepting this authority and taking whatever treatment was recommended. The following quotation is typical regarding treatment expectations:

> Well that I don't know. See it's all according to these people here, you know. Because the way I feel, well these people knows best, they knows best what's right for me, because I don't. As I say I'm satisfied to stay until, until I gets better in whatever the hell is wrong.

These subjects did not tend to see either group therapy or occupational therapy as a major part of their treatment. The nursing staff were seen as carrying out the medical staff's orders, in giving out prescribed medication and in physical and custodial care, and were not seen as part of a therapeutic 'team'. Other patients were perceived as being treated simultaneously by the same people, but were not considered to be part of a shared therapeutic process. Psychiatric treatment was generally considered to consist of answering questions or accepting whatever medication was prescribed. These subjects did not think they should be involved in any decisions about their own treatment. The role of the psychiatrist was described as follows:

> To help people with their problems. Well they get down to see what makes you tick I guess, or what's wrong with you. Then they'll put you on, like they did with me ... he's (his psychiatrist) got me on some medication and right now, I mean he must know what he's doing. He's gone and changed the medication again, for what reason I don't know. I guess he knows that maybe it's not the right medication, I don't know. I'm sure he knows what he's doing more than what I do.

So many subjects in this category might not have been expected, given the emphasis in the units of a regime based on the therapeutic community, to give this view. But these subjects tended to be satisfied with the treatment they were receiving and did not perceive any role incongruence. At most they expressed surprise at the number of questions which they were obliged to answer. For example, one

subject described the role of the psychiatrist in the following way:

> They ask you so many questions, obviously they want to find out the root of the trouble. They must do because they ask - the questions they ask is nobody's business. They go away back to things that take you all your time to remember when you were at school, you know. But I suppose again that's maybe they're trying to find out if there's anything deep down at the root of it.

These subjects, then, had adopted the medical sick role in a psychiatric setting. Of course the subjects in this research had only been in hospital for a few days and some confusion and anxiety may have contributed to a continued perception of the therapeutic milieu based on previous knowledge and experience of the more familiar medical setting. Although they had been in hospital long enough to be aware of ward routine at least, it is likely that they had only had one or two interviews with their psychiatrist. In fact a number of subjects in this category were not sure of the type of treatment they would receive and stressed the fact that they were undergoing diagnosis and were waiting for decisions to be made by the psychiatrists. It may be that, had they been interviewed several days later, once they had discovered more about the wards and their organisation, that some dissatisfaction might have been expressed, and they may have been similar to those in category (b).

It seems that unless a ward or unit has an explicitly adhered to therapeutic community milieu, it is possible for some first admission psychiatric patients, in the first stages of their treatment at least, to continue to perceive their role as passive and to express satisfaction with this. The subjects in this category may also have been expressing a strongly held preference for a particular mode of

passive treatment and may even have been resisting the values of the therapeutic community, albeit values which they appeared not to be aware of.

Ten of these subjects had had some experience in the past of treatment on an out-patient basis, and again this would seem to have had a negligible effect on influencing role perception as an 'in-patient'. Similarly, experience of others in a psychiatric hospital does not appear to have had any influence. This will be discussed below.

A sub-group of this category are those mentioned above who basically were displeased at being in hospital but who felt passive and powerless by virtue of the fact of having been hospitalised. There were five such subjects in this category, all of whom felt they had been admitted under pressure. One parasuicide had been admitted on a compulsory basis. The other four subjects had been admitted to hospital after what they considered to be coercive action by significant others or agencies. In these instances the psychiatrist's authority came not only from his status as psychiatrist but also from his role as custodian. These subjects, in particular, in perceiving themselves as passive and the ward milieu as authoritarian and paternalistic may have been expressing some resistance to psychiatric treatment.

(e) Subjects with no Clearly Conceptualised Ideas of their Patient Role

There were five subjects who perceived that they were in a situation which they did not fully understand. They basically saw themselves as

passive and were not opposed to treatment. However, they had not formulated a view of their own or others' roles and had no understanding of what type of treatment to expect.

(f) Subjects Opposed to Receiving Psychiatric Treatment

As mentioned above, all of the subjects in the above categories, even if they had opposed their admission and remained critical of the hospital, appeared to be willing to remain and receive treatment. In contrast there were ten subjects, eight from Newfoundland, who felt they did not need treatment, who did not want to be in hospital and who were planning to arrange their discharge. Only three of these subjects thought they had any sort of problem. Nine of the ten felt they had been compelled into their psychiatric admissions by the actions of significant others or agencies.

These subjects, more than any others in this research, felt they were being 'labelled' as mentally ill. Despite this feeling of being coerced into an admission, only two in fact had been admitted on an involuntary or compulsory basis. One other, however, said that this had been offered as an alternative if he did not co-operate. This subject said he was planning to discharge himself after the interview:

> He (the psychiatrist) gave me an alternative. He suggested that I come in here for a few days. I said if I don't come in what happens? 'Well I'm not going to tell you but we may compel you to come in, otherwise a Section 31 of the Mental Health Act'. So I took the gamble and said I don't want to come in here because I felt quite able to go home. So he says, 'Right we'll slap 31 on you'. And it was only then I persuaded him that I would come in here for two or three days.

Subjects' Characteristics and Perceptions of the Patient Role and the Ward Milieu

The ways in which these subjects described their patient role and the ward milieu are summarised in Table 8:4.

TABLE 8:4 Subjects' Perceptions of the Patient Role/Ward Milieu

Perceptions of Patient Role/ Ward Milieu		No. of Subjects
(a)		21
(b)		17
(c)		12
(d)		35
(e)	no clear view	5
(f)	wanted discharge	10
	Total	100

The individual categories and the types of subject subscribing to each are considered in this section. Of central interest in this thesis are the subjects' experiences of becoming psychiatric patients. For this reason the subjects are also grouped here into those seeing their patient role as 'active' (those in categories (a) and (c)) and those seeing their patient role as 'passive' (b) and (d). These combined categories are also focussed on in this section.

Table 8:5 shows that Edinburgh subjects (30.6%) were most likely to consider their patient role as active and to think that the ward milieu was based on dynamic psychotherapeutic treatment and a democratic sharing of responsibilities (a). They were also more likely than Newfoundland subjects to subscribe to categories (b) and (c) - to see their role as passive while considering that the ward milieu was based on dynamic, psychotherapeutic treatment and a democratic sharing of responsibilities and to see their role as active but the ward milieu as

hierarchical and/or paternalistic with a major emphasis on physical treatment (Table 8:5). Newfoundland subjects were considerably more likely to subscribe to (d) - to consider their patient role and the ward milieu as hierarchical and/or paternalistic with a major emphasis on physical treatment. Half the Newfoundland subjects described their role and the ward milieu in this way. In addition, Table 8:5 shows that Newfoundland subjects (17.4%) were considerably more likely than Edinburgh subjects to feel they did not need treatment, wished to leave hospital and were planning their discharge.

As was mentioned above, the way these subjects perceived both their patient role and the ward milieu seemed to some extent to have been influenced by the type of ward or unit which they had been admitted to. The ward regime itself and the extent to which the psychiatric patient role had been made explicit were thought to have been influential in this. This appeared to vary among the wards or units in this research and between the two locations. It is perhaps not surprising that a high proportion of subjects in category (a) were Edinburgh subjects and patients in the Professorial Units - units where the idea of the therapeutic community was made explicit.

The difference between the two locations may also indicate differences in attitudes towards hospitalisation. Subscribing to category (a) may be the result of receptiveness to psychiatry and psychiatric treatment. Subscribing to (d) may indicate 'traditional' views of medical practice.

TABLE 8:5 Subjects' Perceptions of the Patient Role/Ward Milieu (all categories) by Location

Perceptions of Patient Role/ Ward Milieu	Location Edinburgh	Newfoundland	Total
(a)	15 (30.6%)	6 (13.0%)	21
(b)	12 (24.5%)	5 (10.9%)	17
(c)	8 (16.3%)	4 (8.7%)	12
(d)	12 (24.5%)	23 (50.0%)	35
(f)	2 (4.1%)	8 (17.4%)	10
Total	49	46	95

Category (e) subjects are excluded here and in subsequent Tables. They are counted as not being coded

When only the patient role dimension is considered and 'active' subjects are compared with 'passive' subjects, the differences between the two locations remain apparent. The relationship between location and patient role is significant at the 0.05 level. Edinburgh subjects were considerably more likely than Newfoundland subjects to see their role as active (48.9% compared to 26.3%) and Newfoundland subjects were most likely to see their role as 'passive' (73.7%).

TABLE 8:6 Subjects' Perceptions of the Patient Role (combined categories) by Location

Perceptions of Patient Role	Location Edinburgh	Newfoundland	Total
Active (a) and (c)	23 (48.9%)	10 (26.3%)	33
Passive (b) and (d)	24 (51.1%)	28 (73.7%)	52
Total	47	38	85

$x^2 = 4.52$, df = 1, $p < 0.05$

Totals are less than 100 because those not coded on 'patient role/ ward milieu perspectives' and those wishing to be discharged are excluded from this and subsequent 'combined category' Tables

If seeing the patient role and the ward milieu in a particular way did reflect attitudes to psychiatry and if it reflects their feelings about becoming a psychiatric patient, then it would be expected that there would be a relationship between how they described mental illness and the mentally ill (and hence how they felt about being labelled as such themselves) and their role perceptions.

Table 8:7 shows that those who described mental illness as a wide range of conditions were most likely to see their role as active and the ward milieu as 'democratic' (35.1%). This again indicates an acceptance of a 'psychiatric' view. In contrast, only 7.4% of those who described the mentally ill in terms of a stereotype only thought of their role and the ward milieu in this way (Table 8:7). A greater proportion of those who saw mental illness as a wide range of conditions also described their role as 'active' and the ward milieu as authoritarian/paternalistic (18.9%). But subjects in this category did

not tend to view their role as passive and the ward milieu as authoritarian/paternalistic (21.6%) when compared to the subjects describing mental illness in the other two ways.

That there is some relationship between attitudes to mental illness and role perception is also evident in that 18.5% of those who described mental illness in terms of a negative stereotype only were in category (f) - they did not consider that they needed treatment and wished to be discharged from hospital.

These findings to some extent reflect the differences in the two locations both for conceptions of mental illness and role/ward milieu perceptions.

A higher proportion of subjects describing mental illness as 'depression' only (24%) were found in category (b) than the groups describing mental illness in either of the other two ways. It was noted above that subjects in this category tended not to be among those suffering from substance abuse problems. A high proportion emphasised somatic problems and depression or anxiety. This emphasis probably reflects their own conditions.

TABLE 8:7 Subjects' Perceptions of the Patient Role/Ward Milieu (all categories) by Conceptions of Mental Illness

Perceptions of Patient Role/ Ward Milieu	Conceptions of Mental Illness: Stereotypes	Depression/ Anxiety	Both	Total
(a)	2 (7.4%)	6 (24.0%)	13 (35.1%)	21
(b)	4 (14.8%)	6 (24.0%)	6 (16.2%)	16
(c)	3 (11.1%)	2 (8.0%)	7 (18.9%)	12
(d)	13 (48.1%)	11 (44.0%)	8 (21.6%)	32
(f)	5 (18.5%)	-	3 (8.1%)	8
Total	27	25	37	89

Totals are less than 100 because of those not coded on 'conceptions' and 'patient role/ward milieu perspectives'

The distribution of the subjects' conceptions of mental illness and their role perceptions is considered in Table 8:8. This relationship is significant at the 0.05 level. Subjects who described the mentally ill in terms of a negative stereotype only (and therefore who, it was suggested, rejected the label of mental illness and were concerned about the consequences of being labelled as such) were more likely to see their own patient role as passive (77.3%) than were either of the other two groups. However, both those who used stereotypes only and those who described mental illness as depression or anxiety only were considerably more likely to see their patient role as passive than active. Only the group who described mental illness as a wide range of conditions were more likely to see their role as active (58.8%) than passive (41.2%) (Table 8:8). Indeed, 20 of the 33 who said this role was 'active' also described mental illness as a wide range of conditions. Again they appeared to be advancing an 'educated' view of both psychiatric disorder and an 'informed' view of their patient role.

TABLE 8:8 Subjects' Perceptions of the Patient Role (combined categories) by Conceptions of Mental Illness

Perceptions of Patient Role	Conceptions of Mental Illness: Stereotypes	Depression/ Anxiety	Both	Total
Active (a) and (c)	5 (22.7%)	8 (32.0%)	20 (58.8%)	33
Passive (b) and (d)	17 (77.3%)	17 (68.0%)	14 (41.2%)	48
Total	22	25	34	81

$x^2 = 8.345$, df = 2, $p < .05$

Few differences emerge when the subjects' views on aetiology are compared to their perceptions of the patient role and the ward milieu (Table 8:9). Those assigning blame or responsibility to the individual for causing his or her illness were more likely to see their role as passive and the ward milieu as 'democratic' (27.1%) than those who did not assign such blame (9.7%). While the 'multi-category' subjects (those giving more than one view on aetiology) were thought to be among those advancing an 'educated' and 'informed' view of psychiatry, they did not subscribe to category (a) to the exclusion of other views on the patient role and the ward milieu. In fact as Table 8:9 shows, 30% of these subjects said they wanted to be discharged.

TABLE 8:9 Subjects' Perceptions of the Patient Role/Ward Milieu (all categories) by Views on the Aetiology of Mental Illness (combined categories)

Perceptions of Patient Role/ Ward Milieu	Aetiological Themes: No Individual Blame (a) (b) (c)	Individual Blame (d) (e) (f)	Multi-category	Total
(a)	8 (25.8%)	10 (20.8%)	3 (30.0%)	21
(b)	3 (9.7%)	13 (27.1%)	-	16
(c)	6 (19.4%)	5 (10.4%)	1 (10.0%)	12
(d)	12 (38.7%)	16 (33.3%)	3 (30.0%)	31
(f)	2 (6.5%)	4 (8.3%)	3 (30.0%)	9
Total	31	48	10	89

It was seen in Chapter 6 that those who described mental illness in terms of a stereotype only were slightly more likely to assign blame to the individual than were others. It was thought that this might reflect a generally negative attitude. When role perceptions are considered it appears that while individuals not attaching blame were more or less equally likely to see their patient role as active or passive, those assigning blame to the individual were far more likely to see their role as passive (65.9%) than active (34.1%) (Table 8:10).

TABLE 8:10 Subjects' Perceptions of the Patient Role (combined categories) by Views on the Aetiology of Mental Illness (combined categories)

Perceptions of Patient Role	Aetiological Themes: No Individual Blame (a) (b) (c)	Individual Blame (d) (e) (f)	Total
Active (a) and (c)	14 (48.3%)	15 (34.1%)	29
Passive (b) and (d)	15 (51.7%)	29 (65.9%)	44
Total	29	44	73

$x^2 = 1.469$, df = 1, n.s.

Consistent with other findings is that those who felt compelled into their psychiatric admission tended less than others (12.1%) to have described their patient role as active and the ward milieu as 'democratic' (a) (Table 8:11). Category (b) was subscribed to more by those who felt compliant in the admission process than by the other two groups. This is possibly because of the number who, in both of these categories, had been admitted to hospital because of depression. This is consistent with the findings in Table 8:7 where those who described mental illness as depression only tended to be over-represented in this category. Finally, nine of the 10 who wished to be discharged from hospital had also felt compelled into their admission (Table 8:11).

TABLE 8:11 Subjects' Perceptions of the Patient Role/Ward Milieu (all categories) by Perceptions of the Admission Process (combined categories)

Perceptions of Patient Role/ Ward Milieu	Perceptions of the Admission Process: Help seeking	Compliant	Compelled	Total
(a)	11 (27.5%)	6 (27.3%)	4 (12.1%)	21
(b)	7 (17.5%)	6 (27.3%)	4 (12.1%)	17
(c)	7 (17.5%)	-	5 (15.1%)	12
(d)	14 (35.0%)	10 (45.4%)	11 (33.3%)	35
(f)	1 (2.5%)	-	9 (27.3%)	10
Total	40	22	33	95

Subjects who described the process leading to the psychiatric admission as one in which they had been seeking help were more likely (46.1%) than the other two groups to see their patient role as 'active'. Table 8:12 also shows that 72.7% of those who felt compliant in the admission process saw their patient role as passive. Again this

partly reflects these subjects' own conditions. Subjects who themselves were depressed appear to have been most likely to feel passive.

TABLE 8:12 Subjects' Perceptions of the Patient Role (combined categories) by Perceptions of the Admission Process (combined categories)

Perceptions of Patient Role	Perceptions of the Admission Process: Help seeking	Compliant	Compelled	Total
Active (a) and (c)	18 (46.1%)	6 (27.3%)	9 (37.5%)	33
Passive (b) and (d)	21 (53.8%)	16 (72.7%)	15 (62.5%)	52
Total	39	22	24	85

$x^2 = 2.137$, df = 2, n.s.

Females (30.8%) more than males (16.1%) saw their patient role as active and the ward milieu as 'democratic' (a) (Table 8:13). Males (17.9%) more than females (5.1%) subscribed to (c) - seeing their patient role as active but the ward milieu as authoritarian/ paternalistic. This, as was discussed above, may to some extent reflect the higher proportion of subjects with alcohol problems in category (c). Table 8:13 also shows that more males (14.3%) than females (5.1%) wanted to be discharged from hospital. Altogether this possibly indicates less dissatisfaction on the part of female than male subjects.

TABLE 8:13 Subjects' Perceptions of the Patient Role/Ward Milieu (all categories) by Sexual Status

Perceptions of Patient Role/ Ward Milieu	Sexual Status Female	Male	Total
(a)	12 (30.8%)	9 (16.1%)	21
(b)	7 (17.9%)	10 (17.9%)	17
(c)	2 (5.1%)	10 (17.9%)	12
(d)	16 (41.0%)	19 (33.9%)	35
(f)	2 (5.1%)	8 (14.3%)	10
Total	39	56	95

Practically no differences emerge when the combined categories for patient role only are considered.

TABLE 8:14 Subjects' Perceptions of the Patient Role (combined categories) by Sexual Status

Perceptions of Patient Role	Sexual Status Female	Male	Total
Active (a) and (c)	14 (37.8%)	19 (39.6%)	33
Passive (b) and (d)	23 (62.2%)	29 (60.4%)	52
Total	37	48	85

$x^2 = 0.023$, df = 1, n.s.

Subjects aged 45 and above were less likely than younger subjects to subscribe to (a) - to see their patient role as active and the ward milieu as 'democratic' (12.5%) (Table 8:15). A higher proportion of such subjects saw their patient role as passive and the ward milieu as 'democratic' (b) (25%). They also slightly more frequently than other subjects saw their role as 'passive' and the ward milieu as

authoritarian/paternalistic (41.7%). A higher proportion of the youngest age group said they wanted to be discharged from hospital (15.4%) (Table 8:15).

TABLE 8:15 Subjects' Perceptions of the Patient Role/Ward Milieu (all categories) by Age

Perceptions of Patient Role/ Ward Milieu	Age 29 and under	30-44 years	45 and above	Total
(a)	10 (25.6%)	8 (25.0%)	3 (12.5%)	21
(b)	5 (12.8%)	6 (18.7%)	6 (25.0%)	17
(c)	5 (12.8%)	4 (12.5%)	3 (12.5%)	12
(d)	13 (33.3%)	12 (37.5%)	10 (41.7%)	35
(f)	6 (15.4%)	2 (6.3%)	2 (8.3%)	10
Total	39	32	24	95

Table 8:16 shows that the oldest group of subjects were most likely to see their role as passive (72.7%) followed by the middle group (60.0%) then the youngest subjects (55.5%). The pattern is reversed for those seeing their role as 'active'. This likely reflects attitudes towards medicine and the medical profession in general. Older subjects, it was suggested in Chapter 7, probably had a more traditional view of medicine than younger subjects and this is reflected in their descriptions of the patient role.

TABLE 8:16 Subjects' Perceptions of the Patient Role (combined categories) by Age

Perceptions of Patient Role	Age 29 and under	30-44 years	45 and above	Total
Active (a) and (c)	15 (45.5%)	12 (40.0%)	6 (27.3%)	33
Passive (b) and (d)	18 (55.5%)	18 (60.0%)	16 (72.7%)	52
Total	33	30	22	85

$x^2 = 1.865$, df = 2, n.s.

As can be seen in Table 8:17 there were a few small differences between married and unmarried subjects. Married (21.9%) more than unmarried subjects (14.8%) described their role as passive and the ward milieu as 'democratic' (b) and also the ward milieu as authoritarian/paternalistic and their role as passive (d) (43.9% compared to 31.5%). Nine of the 10 subjects who said they wished to be discharged from hospital were 'unmarried' (Table 8:17). Married subjects tended to be older on average than unmarried subjects in this research. Some of the patterns for marital status reflect those for age (see Tables 8:15 and 8:16).

TABLE 8:17 Subjects' Perceptions of the Patient Role/Ward Milieu (all categories) by Marital Status

Perceptions of Patient Role/ Ward Milieu	Marital Status Unmarried	Married	Total
(a)	12 (22.2%)	9 (21.9%)	21
(b)	8 (14.8%)	9 (21.9%)	17
(c)	8 (14.8%)	4 (9.8%)	12
(d)	17 (31.5%)	18 (43.9%)	35
(f)	9 (16.7%)	1 (2.4%)	10
Total	54	41	95

These patterns are also apparent when role perception only is considered. Unmarried subjects (44.4%) more than married subjects (32.4%) saw their patient role as active. This contrasts with 67.5% of married and 55.6% unmarried subjects describing their role as passive. Again this is somewhat similar to the pattern for age.

TABLE 8:18 Subjects' Perceptions of the Patient Role (combined categories) by Marital Status

Perceptions of Patient Role	Marital Status Unmarried	Married	Total
Active (a) and (c)	20 (44.4%)	13 (32.5%)	33
Passive (b) and (d)	25 (55.6%)	27 (67.5%)	52
Total	45	40	85

$x^2 = 1.271$, df = 1, n.s.

When education level is considered it appears that those most likely to see their patient role as active and the ward milieu as 'democratic' (a) were those with some university or college education (36%) (Table 8:19). These subjects were also more likely than the

other two groups to subscribe to (c) - the patient role as 'active' and the ward milieu as authoritarian/paternalistic. They were least likely to want to be discharged from hospital (4%). Table 8:19 also shows a contrast in that those with under nine years of education were most likely (53.1%) to see themselves as passive and the ward milieu as authoritarian/paternalistic (d). Education, then, appears to be related to role perception and views of the ward milieu.

TABLE 8:19 Subjects' Perceptions of the Patient Role/Ward Milieu (all categories) by Education Level

Perceptions of Patient Role/ Ward Milieu	Education Level 0-9 years	10-13 years	University/ College	Total
(a)	4 (12.5%)	8 (21.0%)	9 (36.0%)	21
(b)	4 (12.5%)	10 (26.3%)	3 (12.0%)	17
(c)	4 (12.5%)	3 (7.9%)	5 (20.0%)	12
(d)	17 (53.1%)	11 (28.9%)	7 (28.0%)	35
(f)	3 (9.4%)	6 (15.8%)	1 (4.0%)	10
Total	32	38	25	95

The relationship between role perception only in the combined categories and education level is seen in Table 8:20. Consistent with that in Table 8:19 is that subjects with university or college education were more likely than the other two groups to see their role as active (58.3%). Those with under nine years of education were most likely to see their role as passive (72.4%). A higher level of education, then, may indicate a tendency to adopt a psychiatric frame of reference and to present an 'informed' and 'educated' perspective.

TABLE 8:20 Subjects' Perceptions of the Patient Role (combined categories) by Education Level

Perceptions of Patient Role	Education Level 0-9 years	10-13 years	University/ College	Total
Active (a) and (c)	8 (27.6%)	11 (34.4%)	14 (58.3%)	33
Passive (b) and (d)	21 (72.4%)	21 (65.6%)	10 (41.7%)	52
Total	29	32	24	85

$x^2 = 5.651$, df = 2, n.s.

As can be seen in Table 8:21 non-manual workers (34.1%) more frequently than manual workers (12.9%) saw their role as active and the ward milieu as 'democratic' (a). Manual workers more often subscribed to category (d) - the patient role as passive and the ward milieu as authoritarian/paternalistic (42.6% compared to 29.3%). This is consistent with the findings for education level. Manual workers also more frequently than non-manual workers subscribed to (c) - the patient role as active and the ward milieu as authoritarian/paternalistic (16.3% compared to 7.3%) (Table 8:21). This again may partly have been because of the predominance of male subjects with alcohol dependence problems in this category. Males as a whole were overrepresented in the 'manual' category.

TABLE 8:21 Subjects' Perceptions of the Patient Role/Ward Milieu (all categories) by Occupational Status

Perceptions of Patient Role/ Ward Milieu	Occupational Status Non-manual	Manual	Total
(a)	14 (34.1%)	7 (12.9%)	21
(b)	8 (19.5%)	9 (16.7%)	17
(c)	3 (7.3%)	9 (16.7%)	12
(d)	12 (29.3%)	23 (42.6%)	35
(f)	4 (9.8%)	6 (11.1%)	10
Total	41	54	95

These differences are also seen in Table 8:22. The patient role was described as passive more frequently by manual (66.7%) than by non-manual workers (54.1%). A greater proportion of non-manual (45.9%) than manual workers (33.3%) described their role as active.

TABLE 8:22 Subjects' Perceptions of the Patient Role (combined categories) by Occupational Status

Perceptions of Patient Role	Occupational Status Non-manual	Manual	Total
Active (a) and (c)	17 (45.9%)	16 (33.3%)	33
Passive (b) and (d)	20 (54.1%)	32 (66.7%)	52
Total	37	48	85

$x^2 = 1.403$, df = 1, n.s.

A similar contrast is seen between categories (a) and (d) when subjects currently employed are compared with those not employed. (Table 8:23). Those employed were more likely to see their role as active and the ward milieu as democratic (26.5%) than those not employed.

Those not employed most often saw their role as passive and the ward milieu as authoritarian/paternalistic (43.5%). In addition, Table 8:23 shows that a higher percentage of subjects not employed (15.2%) than employed (6.1%) wanted to be discharged from hospital.

TABLE 8:23 Subjects' Perceptions of the Patient Role/Ward Milieu (all categories) by Employment Status

Perceptions of Patient Role/ Ward Milieu	Employment Status Employed	Not Employed	Total
(a)	13 (26.5%)	8 (17.4%)	21
(b)	10 (20.4%)	7 (15.2%)	17
(c)	8 (16.3%)	4 (8.7%)	12
(d)	15 (30.6%)	20 (43.5%)	35
(f)	3 (6.1%)	7 (15.2%)	10
Total	49	46	95

This is also evident when role perception only is considered in the combined categories (Table 8:24). Subjects not currently employed (69.2%) more frequently than employed subjects (54.3%) saw their patient role as passive. Those employed (45.7%) were more likely than those not employed (30.8%) to view this role as active.

TABLE 8:24 Subjects' Perceptions of the Patient Role (combined categories) by Employment Status

Perceptions of Patient Role	Employment Status Employed	Not Employed	Total
Active (a) and (c)	21 (45.7%)	12 (30.8%)	33
Passive (b) and (d)	25 (54.3%)	27 (69.2%)	52
Total	46	39	85

$x^2 = 1.966$, df = 1, n.s.

One characteristic which might have been expected to have been influential in how these subjects viewed their patient role and the ward milieu is that of experience of psychiatry. It might be expected that those with experience themselves as out-patients or with experience of friends or family who had had psychiatric treatment would be most likely to have gained an understanding of the dynamics of psychiatry and would describe their role as active and the ward milieu as democratic (a). Indeed, as was discussed above, some of the subjects in this category said they had been explicitly told what treatment to expect in the units or wards. However, as Table 8:25 shows, those with 'high' experience of psychiatry (24.5%) were only slightly more likely than those with 'low' experience (19.6%) to subscribe to this category. However they were also slightly less likely than those with low experience to see their role as passive and the ward milieu as authoritarian/paternalistic (d) (32.6% compared to 41.3%) (Table 8:25).

TABLE 8:25 Subjects' Perceptions of the Patient Role/Ward Milieu (all categories) by Experience of Psychiatry

Perceptions of Patient Role/ Ward Milieu	Experience of Psychiatry Low	High	Total
(a)	9 (19.6%)	12 (24.5%)	21
(b)	7 (15.2%)	10 (20.4%)	17
(c)	7 (15.2%)	5 (10.2%)	12
(d)	19 (41.3%)	16 (32.6%)	35
(f)	4 (8.7%)	6 (12.2%)	10
Total	46	49	95

There were practically no differences when role perception only is considered (Table 8:26). It would seem, then, that simply having some experience of psychiatry does not necessarily mean accepting the requirements of and adopting the patient role.

TABLE 8:26 Subjects' Perceptions of the Patient Role (combined categories) by Experience of Psychiatry

Perceptions of Patient Role	Experience of Psychiatry Low	High	Total
Active (a) and (c)	16 (38.1%)	17 (39.5%)	33
Passive (b) and (d)	26 (61.9%)	26 (60.3%)	52
Total	42	43	85

$x^2 = 0.02$, df = 1, n.s.

The subjects, then, subscribed to five categories on their perceptions of the patient role and the ward milieu. Their views of the patient role as 'active' versus 'passive' were also considered.

In terms of the types of subject subscribing to each view, most of the differences remained when the categories were collapsed and the patient role only was considered. However, females more than males saw their role as 'active' and the ward milieu as 'democratic' (a). This contrasts with (c) where more males saw their role as 'active' but the ward milieu as 'authoritarian/paternalistic'. Those who subscribed to (c) tended to be subjects with substance abuse problems who also tended in this sample to be male. The greater proportion of manual workers in (c) largely reflects the number of males in this category.

The other difference in the individual categories was that those with 'high' psychiatric experience tended slightly less to subscribe to (d) - seeing the patient role as passive and the ward milieu as 'authoritarian/paternalistic'.

The fifth category, which was not included in the separate analysis of role perception, was where subjects did not wish treatment and wished to be discharged from hospital. Only 10 subscribed to this. These were the most resistant to being psychiatric patients. They tended to be Newfoundland subjects, to have described mental illness in terms of a stereotype only, to have felt compelled into their psychiatric admission, males, unmarried subjects, not employed, under 30 years of age and with less than university or college education.

Because the central concern of this thesis is the subjects' experiences of becoming psychiatric patients, those seeing their patient role as 'active' were compared with those seeing their patient role as 'passive'.

Subjects seeing their role as 'active' tended more to be Edinburgh subjects, those who described mental illness as a wide range of disorders, and those who said they were 'help seekers'. Those who were 'passive' in their patient role were more frequently Newfoundland subjects, those who described mental illness in terms of a negative stereotype only or as depression only, those who assigned blame to the individual for causing his or her illness and those who felt compliant in the admission process.

Younger subjects (those 29 and under), unmarried subjects, those with university or college education, non-manual and employed workers tended to see their role as 'active'. It may be, then, that to some extent subjects with greatest resources were most likely to be receptive

to psychiatry.

Seeing one's role as passive, however, does not necessarily reflect resistance to psychiatry. It may simply be associated with a traditional view of medicine. The subjects viewing their role in this way tended more to be over 44 years of age, married, had under nine years of education, were manual workers and not currently employed.

Conclusion

This chapter has considered the subjects' expectations of the hospital and compared these to what they found. It has also considered the influence of the media on their attitudes. The main focus, however, was their perceptions of the ward milieu and of their role as psychiatric patients.

Most subjects appear to have entered the hospital with few preconceived notions of what to expect in the way of treatment. Expectations were more often based on extreme views of what other patients might be like or of the general nature of institutions. Most expressed the view that they were fairly satisfied with the hospital environment in which they found themselves although some continued to express anxiety about some of the other patients.

Much of the literature on attitudes to mental illness argues that the media perpetuates stereotypes of the mentally ill. Some subjects said they had seen or heard this type of information and it had adversely affected their expectations. Most, however, thought their expectations had not been influenced in a direct way. A large number said they could not recall ever having seen or heard material of this type.

How these subjects viewed their patient role and the ward milieu

appears to have been influenced by a number of variables - these are the ward or unit and the type of therapeutic practices therein, the extent to which the ward ideology or routine had been explained, the subjects' own conditions as well as their views of psychiatry and their feelings about becoming psychiatric patients. The influence of each of these is difficult to isolate.

The ward itself and the therapeutic situation therein seems to have played a dominant part in influencing perceptions of the ward as 'democratic' and the patient role as active (a). A large proportion of subjects in this category were in units where the therapeutic community was adhered to and where it was made explicit to new patients. The subjects' own conditions appear to have influenced the views in (b) and (c). The former - seeing the ward as 'democratic' but the patient role as 'passive' - appears frequently to have been subscribed to by those suffering from depression and not by those with alcohol dependency problems. The latter - seeing the ward as 'authoritarian and/or paternalistic' and the patient role as 'active' - was mostly subscribed to by subjects with alcohol or drug related problems. Their views seem to have developed prior to their admission from knowing others who had had treatment for similar problems or from experience with Alcoholics Anonymous.

Subjects seeing their role as 'active' were also contrasted with those seeing their patient role as 'passive'. Most of the difference among the individual categories were also found between these two broad categories. The fifth category was not included. These were the subjects who did not wish to receive treatment and did not wish to remain in hospital. There were only 10 of these. They tended to be

Newfoundland subjects, those who described mental illness in terms of a negative stereotype only, those who felt compelled into the admission, males, unmarried subjects, those not employed and with less than university or college education.

Consistent with other findings which indicate receptivity to psychiatry was that subjects describing their patient role as 'active' frequently tended to be among those who described mental illness as a wide range of conditions and those who saw themselves as 'help seekers'. They were also more frequently Edinburgh than Newfoundland subjects.

Viewing the patient role as 'passive', however, does not necessarily indicate the opposite view. It seems that resistance is not indicated simply by viewing the role in this way. This appears to be the adoption of the psychiatric sick role in a psychiatric setting. The subjects describing their role as passive tended to be older than those seeing their role as 'active' and their views may partly reflect a more traditional view of medical practice.

Having resources seems to some extent to be also associated with viewing the patient role as either 'active' or 'passive'. For example, the former tended to be advanced more by those with university or college education, non-manual and employed workers.

It would also appear that simply having some experience of psychiatry does not necessarily mean accepting the requirements of and adopting the psychiatric patient role. It was suggested above that experience of others receiving psychiatric treatment seems to have been influential only where the others' problems were similar to those of the subject concerned and where these were discussed recently. In addition, even where the subjects themselves had had psychiatric out-patient treatment, this may have been on

a one-to-one basis with an emphasis on medication. They may have not been socialised into a psychiatric patient role.

Although some of these subjects - most notably those in category (b) and some in (c) - were critical of some aspects of the hospital or the ward milieu, were confused about their role as patient, and were dissatisfied with some aspects of the treatment situation, all of the subjects discussed above indicated that they accepted the need for treatment and were willing to remain in hospital, at least for a while. Overall, very few subjects expressed total dissatisfaction with the treatment they were receiving in terms of it not according with their expectations. For whatever reason they had been admitted to hospital, most appear to have found relief from simply having been hospitalised.

As was seen in Chapter 2, Weinstein (1981) found that a large number of quantitative studies indicated positive attitudes towards the psychiatric hospital on the part of patients. Labelling theory, he argues, has been supported by some qualitative studies which found negative attitudes. The present research then would not lend overall support to labelling theory in this respect.

As mentioned above, the issue of the psychiatric sick role appears to be problematic. It was thought that people entering psychiatric hospitals for the first time would base their understanding of the patient role on their knowledge and experience of this in general medicine. The suitability of this in psychiatric practice appears to be problematic. As was discussed in Chapter 2, the literature in this area generally argues that conflicts may emerge where patients do not share the same definition of the therapeutic situation as the psychiatric staff (cf. Sobel and Ingalls 1968, Tuckett 1976b, Skodol et al 1980).

However, the majority of subjects in this research, despite being generally vague about what they expected, were not critical of what they found. They expressed some criticisms but most were generally satisfied with the treatment situation. Other research, as was seen in Chapter 2, has found similar results (cf. Linn, 1969; Ferguson, 1974; Weinstein, 1981).

It may be that the contrast between the medical and the psychiatric sick roles only becomes apparent in particular treatment situations. Conflicts would be most apparent in psychotherapeutic situations. Although psychotherapy was a major treatment mode in the wards and units in this research, so were other therapies such as psychotropic medication. Many of these subjects were receiving such medication. Thus, the adoption of a passive patient role was for them consistent with what they perceived as a major and, in some instances, preferred treatment for their problems.

It may also be that most people enter hospitals with a fairly open attitude to what they might receive in the way of treatment. This 'openness' may account for the general high level of satisfaction with hospitalisation and treatment found among these subjects.

Finally, the 'asylum' function emerged as an important consideration for a number of subjects. The simple fact of hospitalisation was perceived as beneficial and therapeutic. Indeed, for many who may have been living under considerable pressure, in stressful environments or in extremely difficult interpersonal situations, withdrawing may indeed have been therapeutic simply because of a reduction of stress and consequent relief.

CHAPTER 9

Stigma and the Psychiatric Patient

As was seen in Chapter 2, the research on the effects of having been in a psychiatric hospital is inconclusive. However, attitudes towards psychiatric patients appear to remain somewhat negative, although perhaps less so than earlier literature on the subject would indicate, and it seems likely that having been a patient in a psychiatric hospital may result on occasion in some discrimination. Relating this literature to the present study is problematic in that it tends to address either the views of the public or those of former patients. Nevertheless it might be expected that some subjects in this research would anticipate negative consequences of their experience as psychiatric patients, although several issues indicate the complexity of this matter.

Stigma related to mental illness is generally believed to be somewhat associated with gross stereotypes of the mentally ill which, as was discussed above, revolve around expectations of unpredictability and dangerousness (Nunnally, 1961; Scheff, 1966 and others). As was seen in Chapter 5, many of the subjects in this research described the mentally ill in terms of such stereotypes. These particular subjects reserved the mental illness label for those exhibiting extreme behaviour and did not apply this label to their own condition. Other subjects used such stereotypes to describe an extreme type of mental illness but at the same time applied the mental illness label to their own condition - presenting a broad view of the illness. Still others did not use such stereotypes at all. Yet the potential psychological dilemma of identifying at all with the label of 'mental illness' which may be associated with

unpredictable, bizarre or even dangerous behaviour, remains.

The issue of the meaning of identifying with the mental illness label is further complicated by certain expectations of hospitalisation. That this was seen as the beginning of a deviant career for subjects in this research must be questioned. Most regarded their stay in hospital as short, expecting to be discharged within two weeks at the outside, many expecting to remain in hospital only a few days. This was not unrealistic given the average duration of first admissions. Many subjects in fact said that they had specifically been told that their stay would be '7 to 10 days' or 'two weeks'. This means that they tended to regard their being 'psychiatric patients', if in fact they did see themselves in this way, as very temporary. In fact, as was suggested above, the situation has probably changed considerably since the time that writers such as Goffman (1961) and Scheff (1966) discussed the problems associated with psychiatric hospitalisation. Partly as a result of policies directed towards de-institutionalisation, psychiatric patients in general no longer tend to remain in hospital for any considerable length of time.

It is of interest, therefore, to consider how these subjects perceived the related problem of the stigma associated with mental illness and with psychiatric hospitalisation, and in particular how they thought this might affect their personal situation bearing in mind that as they were interviewed soon after their admission their views might change over time. Such an examination should help to elucidate further these subjects' perspectives on the experience of being first admission psychiatric patients.

The Fear of Stigma and Being Admitted to a Psychiatric Hospital

Certain questions in this research elicited these subjects' perspectives on stigma - although the word 'stigma' was not used directly. The first concerned the reasons why these subjects thought people might not seek help from a psychiatric hospital. Another was specifically addressed to the question of stigma - they were asked if, once discharged, they would disclose the fact of their hospitalisation. In addition, their views on discrimination against the mentally ill emerged in response to other questions, such as whether they had known other people who had been psychiatric patients.

Reasons other than the fear of stigma were mentioned by the subjects in this research as deterrents to seeking help from a psychiatric hospital and these reflected their attitudes to their own hospitalisation, expressed at other times in the interview. They included not realising a problem existed, being too depressed to care, being too confused, thinking they could not be helped, being unwilling to admit a problem existed and being afraid - of being badly treated, of being restrained or confined, of other patients and of what they might discover about themselves. However, the deterrent most commonly mentioned, cited by 49 subjects, was stigma.

Cumming and Cumming (1968) found evidence of stigma in two kinds of statements - the first being an 'outright expression of shame or inferiority because of the hospitalisation' and the other being 'an expectation of discrimination or inferior treatment from others' (Cumming and Cumming 1968:412). The subjects in this research gave similar explanations in discussing reasons for not seeking help in a psychiatric hospital. In addition to citing the fear of stigma as a deterrent when

discussing the situation generally, 24 specifically stated, when talking about their expectations of the hospital and their feelings on being admitted, that they had been particularly anxious because of the stigma associated with mental illness and psychiatric hospitalisation. They did not, however, say this had resulted in delays in seeking help, although of course it is possible, and likely, that this fear had played some role in this process.

Feelings of shame or inferiority appear to reflect not only a sense of personal inadequacy, but also a fear of being labelled as a 'psychiatric patient' and consequently being discriminated against. Such feelings of course may also have been determined at the time to some extent by a generally anxious state. Such attitudes are reflected in the following statement from a subject who also admitted that this fear caused anxiety for her:

> But as for me myself it was just an overwhelming fear. And full of apprehension, and bloody well scared to death of what was about to happen. There's this stigmatism attached to this sort of thing and I suppose if one is out of it it doesn't bother them but when you're in control of a certain amount of your faculties, yes it is an embarrassment. It was humiliating and I still feel that it's just bloody awful.

What is remarkable about the statements from these subjects on this topic is the similarity - they all tended to express ideas relating to embarrassment and fear of being discredited, of being labelled as 'crazy', 'nuts', of having the experience of being a psychiatric patient brought up in the future, of losing friends, of being unsure of how people would react to them, of being treated as less than normal, of losing jobs or being unable to obtain work. However, they did not all think this would

affect them personally.

Another subject responded to the question of deterrents to seeking psychiatric help as follows:

> Partly because of what they consider, what I considered as being a stigma. I mean I know people who consider people who've been in a mental hospital for anything, they consider anyone who's come into hospital as being sort of, not necessarily subnormal but abnormal. And they treat them as such.
>
> People are crazy who are in here and you were going to be branded for life, branded for life, and never associate with anyone socially or anything again. You were really finished, you know, if you were here.

Some subjects brought up the idea that the stigma of having been in a psychiatric hospital was more of a problem in the past, but at the same time they were ambivalent and also considered it likely that it remained a problem.

Consulting a psychiatrist was generally considered to be a problem and even if it was less stigmatised than in the past, it was not considered to be a 'normal' and totally acceptable process. Consulting a psychiatrist, and even more so, being admitted to a psychiatric hospital, was not undertaken lightly - particularly given the recognised risks of being stigmatised as a result.

One Edinburgh subject said:

> Yesterday I got really upset and annoyed because one of my good friends said that going to see a psychiatrist was just trendy, like in Woody Allen movies, and there was nothing wrong with people, just that analysis was the thing to do. And I was upset by that because there is something wrong and that's why I went to see a psychiatrist. It's not like it is in America here, maybe it's different there. But it's not just because it's fashionable here.

The very names of the hospitals, as was mentioned in Chapter 8, held fear for some of these subjects. This particularly would appear to reflect a fear of being stigmatised because of having been a patient in one of these hospitals. This problem has not gone unrecognised by hospital authorities who have periodically changed the names both of units and of hospitals. Waterford Hospital, for example, renamed in 1973, was previously entitled the 'Hospital for Mental and Nervous Diseases'. Prior to 1940 it was known as the 'Insane Asylum' - certainly in the lifetime of many of the subjects in this research. Many of the subjects still referred to the hospital as 'the Mental'. Dinham (1977) also notes this use of the title in Newfoundland culture. It remains to be seen if the more recent change will help in a changing of stereotypes or a reduction in the stigma associated with being a patient in the hospital.

The evidence from the perspective of the Edinburgh subjects is not encouraging. Various sections of the present 'Royal Edinburgh Hospital' have gone through a number of title changes outlined in Chapter 3. It would appear, however, from this research, that the fear of and presumably the actual existence of stigma associated with being known as a former patient from any of the units persists. Either the stigma becomes associated over time with the new title, or the previous title remains in current usage.

In discussing such changes, one Edinburgh subject said:

> Oh there's some people will say that fellow was up in the nut house. Because you must remember that this place, Craig House it was, and Craig House to me was a one way ticket at one time, you see. And it'll never lose it's name, Craig House, whether they try to make it Thomas Clouston Clinic * or the Andrew Duncan Clinic or East Craig, Old Craig or whatever it is. It's still Craig House you see, it's still got it's name. To people that are outside they say 'Oh he's in the Craig House', not 'the Thomas Clouston Clinic'.
>
> (* renamed in 1974)

In this research subjects referred to and associated stereotypes and the possibility of being stigmatised with 'The Royal Edinburgh Hospital' and the 'Andrew Duncan Clinic', (1) both current titles, as well as with 'Craig House', 'Jordanburn' and 'West House' - all earlier titles for various parts of the hospital - and with 'Morningside', the area in which the hospital is located.

Strategies for Dealing with the Problem of Stigma

Most subjects indicated that they considered there was some stigma associated with mental illness or psychiatric hospitalisation, but individual concerns and strategies for dealing with this were diverse. Concerns about stigma were elicited not only in responses to questions concerning knowledge of other people who had been psychiatric patients and those concerning the admission process, but also when subjects were asked whether they planned to disclose the fact of their hospitalisation after their discharge. Taking a combination of all these general responses, the subjects can be considered in the following categories:

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(1) Established in 1964

(a) Those who considered that there was a stigma associated with mental illness and/or psychiatric hospitalisation and who, because of this, planned to withhold to some extent information about their history; and

(b) Those who similarly considered that such a stigma existed but who nevertheless planned on disclosing the fact of their hospitalisation.

In addition there were:

(c) Those who felt that information about their psychiatric hospitalisation was already public and therefore that they had no choice in withholding of disclosing information; and

(d) Those who indicated that there was no stigma associated with mental illness and psychiatric hospitalisation.

(a) Those who Planned to Withhold Information about their Psychiatric History

Thirty-six subjects in the sample associated stigma with mental illness and/or hospitalisation and said that because of this they would withhold to some extent information about their hospitalisation - a strategy which Goffman (1963:58) refers to as 'passing'. The explanations which these subjects gave for this choice were based on fears of being discriminated against in ways similar to those discussed in the literature on stereotypes of mental illness. Basically they felt that if they disclosed such information they would, in Goffman's terms, be 'discredited' (1963:57). With a 'master-status' of ex-mental patient they might no longer be trusted - people might think of them as violent and unpredictable, or at the other extreme, as vulnerable and in need of constant protection. Such attitudes they felt might adversely affect future personal relationships, future employment prospects or

even their present relationships or employment situations.

In response to the question of telling others about their having been in a psychiatric hospital, 17 said they would tell a few people, usually family or close friends and in some cases employers and 19 said they wished to disclose such information to no one. In fact, in most of these instances a few significant others already knew about the admission. However, they were distinct from other subjects in this research in that they were all concerned with selecting and limiting the number of others who would possess this information, who in turn would be in a position to disclose details of the individual's psychiatric history.

A typical response of those who said they would withhold information about their problems and their hospitalisation was as follows:

> I wouldn't want anybody to know I was in here. 'Oh my God, you were <u>there</u>?' I'd never hear the last of it. I don't think I would be taken quite as seriously knowing that I'd been here. For some strange reason I don't think anybody would ever believe me after I came out of here.

Explanations for a recent absence from the community varied. One subject, for example, said he would simply say that he had been away on vacation. Two of the Newfoundland subjects, who said they would tell no one, had already had experience with hiding past criminal records and they both compared the disclosure of such information as similarly stigmatising as disclosing information about their psychiatric hospitalisation. One explained:

> Maybe an employer if you went to ask for a job and puts an application, the first thing you see is that medical. Now I've done it before. I've lied on two applications about being in prison. But then again you're thinking well what am I going to say. If I say yes, I've been in an institution, do I get the job or not? Right? I think that's mostly why they would not hire you. Like I say prison, that's down there that you've got a criminal record. And what are you supposed to say to that? If you say yes to that a person is going to say, 'Why should I hire him, he's going to steal'.

Of the Newfoundland subjects who said they wanted no one to know, all but one had been admitted to Waterford Hospital and not to the Health Sciences Psychiatric Unit. Again it would seem that the reputation of the hospital to which a person is admitted plays some considerable part in creating anxieties about being stigmatised. This is illustrated in the following quotation:

> I don't want anybody to find out I was in this place. (Why?) Because it's a mental hospital, that' s what it was called. So they say, they think they're sick, sick people - murderers and everything.

Similar attitudes were expressed by Edinburgh subjects. Two, similar in terms of wishing to totally withhold information, were anxious that their employment might be at risk and were primarily concerned about the title and reputation of 'Craig House'.

> I reacted against it in a way because I didn't want to come. I considered it, as anyone would, you know. We've always sort of looked at this as a lunatic asylum, you know. Craig House - lunatic asylum.

As was discussed above, however, similar reputations were associated with other sections of the Royal Edinburgh Hospital. One subject in this category said:

> I always thought the Andrew Duncan Clinic was where nutters and everything went, crazy.

Other researchers, noted in Chapter 2, have similarly found that former psychiatric patients hide the fact of their hospitalisation. The expressed desire to totally withhold information appears to relate to the degree of fear of being stigmatised. It seems likely that these subjects, more than others in this research, felt less able to control the application by others of a label of 'mentally ill'.

Strategies are available to former psychiatric patients wishing to justify their hospitalisation or rationalise their illness. As was discussed in Chapter 2, several researchers have found that former patients and their families frequently deny that the individual was mentally ill (Schwartz, 1957; Cumming and Cumming, 1968). Similar strategies, and others, were proposed by other subjects in this research and will be discussed in greater detail below.

Of course many studies of stigma consider the position of former patients; comparisons with patients presently in hospital are problematic. Nevertheless the views of the subjects in this research may be considered to indicate general feelings about the problem of stigma.

Justifying hospitalisation or rationalising mental illness is probably more difficult where individuals perceive their admissions as being against their will, as processes in which they exercise little choice. This will be discussed below.

Being admitted on a compulsory or involuntary basis does not appear to be related to an extreme fear of stigma. While three of such subjects said they wanted to totally withhold information, another three said they would disclose the fact of their hospitalisation and one said he would limit the information to a few trusted people. Other circumstances surrounding the admission may be more important than status on admission in determining attitudes.

The statements on stigma made by parasuicides were similar to those of other subjects in this category. They did not state specifically that it was their suicide attempts that would incur stigma rather than the fact of having been in a psychiatric hospital. As a group, however, they were far more inclined to say they wanted to withhold information about their hospitalisation. Although, as was noted earlier, only a small proportion of parasuicides are referred for psychiatric in-patient treatment, it seems likely that this fear was partly based on a general public view which equates suicide attempts with mental illness. In addition such anxieties may have been based on a fear of moral condemnation. Out of 23 parasuicides in the entire sample, only six said they would disclose the fact that they had been patients in a psychiatric hospital. This reluctance is particularly notable for the Edinburgh subjects. In the category where subjects said they wished to totally withhold information, there were nine Edinburgh subjects, five of whom were parasuicides.

This is the only dimension in which the parasuicides differed from other subjects in this research. As was discussed above, parasuicides tended to be similar to other subjects expressing a similar variety of attitudes towards mental illness or towards treatment.

From the evidence given by these subjects, it is difficult to know whether the fear of stigma expressed by the parasuicides was related to a particular embarrassment at having made a suicide attempt or if the fear of stigma because of being in a psychiatric hospital was so great that this prevented their seeking help prior to their suicide attempt.

One Edinburgh subject, for example, was already waiting for an admission to the Unit for the Treatment of Alcoholism which he had agreed to after a consultation with his GP. He subsequently took an overdose of drugs which precipitated his admission to the Royal Edinburgh Hospital. It would seem in this instance that the anxiety associated with stigma played some part in his initial reluctance to obtain an arranged admission. He explained:

> Well to me I was sort of forced in here. I wasn't forced but I had it in my mind that I was going to straighten myself out. But I think it was more embarrassment to the family, like. To say, know with your children suffer through the 'Oh your Dad's in Andrew Duncan' - this carry on. Because you know what kiddies are like, very hard.

It is likely, however, that these parasuicides were similar to other subjects who wished to withhold information; that is they felt it would be more difficult to redefine their hospitalisation and to deny that they were mentally ill. Such redefinition and denial is facilitated with the co-operation of significant others. Therefore, where subjects were admitted after direct intervention by significant others, this denial may not be realistic.

Another group of subjects also wished to withhold information about their hospitalisation, but felt less strongly than those described above. Seventeen said they would deal with the problem of stigma by disclosing

the facts of their illness and their hospitalisation to only a few people. These others were perceived as people who could be 'trusted' to help the subjects hide part or all of their psychiatric history, thus facilitating their 'passing' in society. They also tended to be considered as people who could understand the subjects and their illnesses and likely to be sympathetic and non-judgemental. Goffman (1963) described a similar strategy. For example, one subject, when asked if he would tell people he had been in hospital replied:

> Well some, but I'm not going to walk around saying 'Oh yes, I was in the Andrew Duncan'. There is a stigma for it, you know, when people talk about it. Amongst friends it's OK because they know you well, but people who don't know you, it gives them a different evaluation of what you are.

Several subjects described specific strategies to handle information about their illness and their hospitalisation. These were strategies consciously designed to reduce the effects of stigma and are distinct from psychological mechanisms whereby individuals deny mental illness or redefine hospitalisation to themselves as well as to others. Eight, for example, said they would handle their problematic histories either by saying they were in hospital for what they perceived as a less stigmatising illness or they would somehow conceal the title of the hospital in which they had been a patient. For example, one said:

> I'll try and keep it a secret as much as I can because, the first doctor, she put alcoholism on my slip. I nearly died when I seen that. I said can you no' put acute anxiety or something like that? Even that's bad enough. Tore it up and she put acute anxiety. I mean if that line had went into work, alcoholism, everything that had happened in the past they'd say it had been the cause of it all the time.

Another male Edinburgh subject also considered that stigma was particularly problematic regarding alcoholism and planned to elicit the help of his colleagues at work in hiding information:

> I think they'll (colleagues) say, well he's been working too hard, it's a nervous breakdown, which is much more polite than coming in for alcoholism.

This contrasts with the attitudes of some subjects described above admitted because of drinking problems who wished to make it quite clear that they were not mentally ill and who disassociated themselves from other patients whom they considered as such. It must be concluded that some people consider alcoholism as less discrediting than mental illness, while others take the opposite position. Certainly those subjects who had experience with Alcoholics Anonymous tended to take the former view. Others were less sure of their position and tended to reflect the general ambivalence even of the psychiatric profession towards alcohol related problems. Although alcoholism is not universally regarded as a clinical entity, as was mentioned above, it is classified in the WHO's ninth classification of mental disorders (1978) as a mental disorder and treatment for such problems tends to take place within psychiatric facilities.

In some instances proposed misrepresentation was selective. Some subjects said they would disclose full details to their friends but would tell colleagues they had been in hospital for a different kind of illness - usually a medical problem. Some subjects planned to enlist the co-operation of employers in this strategy. One, with such co-operation, planned to tell others that he was absent from work because of a 'nervous breakdown', and not disclose the fact that a suicide attempt had

precipitated his admission.

One interesting example was a Newfoundland subject who described this strategy for manipulating information and thus reducing the likelihood of being stigmatised:

> Could be a number of reasons why I'm in here - not because I'm depressed. I could be in here because I got a nervous stomach or I got some kind of - could be anything. I mean well mainly I suppose it's depression. But you know there's people down here were up for operations ended up down here. If I had an operation then they could put me down here meantime for psychological. So if anybody asks me I'll say there was a shortage of beds so they had to put me down here.

Thus, being a patient in a psychiatric ward in a general hospital had a distinct advantage in terms of information control in that it would not be necessary to withhold details of which hospital they were in, only the type of ward. This strategy was mentioned by two subjects in the Health Sciences Psychiatric Unit, the other saying:

> Well I can tell them I was in hospital for my nerves. I don't have to say I was in the psychiatric ward.

Another subject in this category, a patient in Waterford Hospital, also considered the Health Sciences Centre to be less stigmatised and said:

> Like when I go home, OK, the neighbours say 'Where have you been? I never saw you for a while'. Well I'm not going to say, 'Oh I was in the Waterford', you know. I'll say I was in the Health Sciences. Like I don't want my reputation to be down in too many ways by the people who now are my friends.

(b) Subjects who Planned to Disclose Information about their Psychiatric History

In contrast to the perspectives and planned strategies discussed above, 45 subjects, despite acknowledging that being a former psychiatric patient could lead to exclusion, distrust - generally being stigmatised - said that they would disclose such information about themselves. This alternative strategy, as was seen in Chapter 2, was also discussed by Goffman (1963).

The subjects who planned to disclose information described the effects of being stigmatised as a former psychiatric patient in similar terms to those who planned to withhold information about themselves, but they were different in terms of how they would deal with it. They gave a variety of explanations for such potentially damaging disclosure.

One type of explanation given focussed on describing to the people to whom they planned to disclose information the beneficial aspects of hospitalisation and how unlike an asylum the hospital in fact was. A variation of this theme was to describe to others how 'normal' psychiatric patients in fact were and how different from the stereotype commonly associated with mental illness. This type of explanation can be seen in the following quotation:

> Well they're going to say, 'He's really retarded, he was in the Mental', 'Hello crazy head' and stuff like this. And they're afraid people are going to call them names and stuff like this, you know, say things about the Mental. But the Mental's not for everybody crazy or anything, the Mental's for everybody that has got serious problems.

Another subject said:

> Oh I think they will think that there is really something wrong with me until maybe I can describe to them what it was like, you know.

The aim of these kinds of explanations for disclosure was to present and to educate others into a 'correct' view of mental illness and psychiatric hospitals. Normalising the experience of having been in a psychiatric hospital serves to reduce the potential stigma of the disclosure.

Alternatively some suggested that in disclosing details of their hospitalisation they would also explain how they had been helped:

> I've been here, I have personal experience of it and I'll be quite happy to sit down with anybody and talk about a place like this, just enlighten them that it's not what they think it is. I wouldnae be ashamed in any way to sit and discuss it with anybody. I realise there's been something wrong with me. I've come here. I've seen to myself. I've had a lot of help.

Some subjects suggested that if the public knew more about psychiatry then the stigma associated with being in hospital would be reduced - a perspective adopted by many health professionals and educators. From the individual's point of view, however, the concern again was a denial of deviance, a normalising of their experience. One subject expressed this view in the following way:

> Like I think psychiatry should be brought out in the open. Like I'm more or less embarrassed of being on psychiatry ... It's hard to say to someone outside 'I got to go to psychiatry', cause they don't know nothing about psychiatry. They think you are a mental patient if you need to go on psychiatry, they don't think of anything else. I think it should be brought out in the open, more or less. Cause if people came and saw what's going on in here there wouldn't be that much of a disturbance on the outside.

Other subjects were more confrontational, saying they would disclose information but if the others rejected them as a result then they in turn would reject them as ignorant. This in effect served a similar purpose to 'educating' others. A choice is offered - the choice being to accept or reject the former psychiatric patient as normal. This view can be seen in the following quotation:

> Well I think if you've ever been here, people who are unintelligent enough not to realise the difference, probably think you're whacko. To tell you the truth those people don't matter too much, you know, because friends like that you don't need.

Other defiant stances were, 'I'm not ashamed', ' couldn't care less what other people think', or 'It won't bother me'. It appears that they wished to demonstrate their lack of embarrassment and therefore their sanity and normality by adopting such a position.

A smaller group of subjects said they were concerned about the stigma associated with having been psychiatric patients but still planned to disclose such information about themselves to others. They tended to express this in fatalistic terms, saying they would 'try to adapt' or that they hoped others would understand. In effect they did not think they had been mentally ill and did not consider it necessary to try to convert others:

> I just decided to tell the truth and hope people will understand. I don't think they're, you know, I'm not going off my head or anything.

These explanations are similar to those found by Cumming and Cumming (1968).

As was seen in Chapter 2, one strategy was to re-define

hospitalisation as a mistake. Very few subjects at this stage in the research actually defined and interpreted hospitalisation 'as a mistake' although Cumming and Cumming (1968) give persons saying they were admitted because of a nervous breakdown and that they were dissimilar to other patients as examples of this. They argue that:

> Thus they establish that this 'cured' person was never 'really crazy', that he was at the time socially incompetent or unpredictable and therefore cannot be now. (Cumming and Cumming, 1968:410)

This mechanism was seen in the more general discussion of the subjects' conceptions of mental illness where they say they were admitted because of problems which they defined differently from 'mental illness' and where they distanced themselves from other patients. It also tended to be reflected in most of the examples where subjects said they planned to disclose details of their hospitalisation. For these subjects it was a basic underlying assumption behind the other explanations for disclosing but possibly inadequate in itself to reduce the effects of stigmatisation.

Again consideration must be taken of the fact that the subjects in the present research were patients in hospital and other research concentrates on the former patient. It may be that some discharged patients would, in fact, for example, re-define hospitalisation as a mistake.

Most subjects who planned to disclose information tended to have adopted a mechanism similar to one described by Cumming and Cumming whereby the public is perceived as ignorant and prejudiced. All of these subjects - those planning to 'educate' and those planning to 'confront' were involved in distancing themselves from the effects of

stigma by stressing the fact that they were not 'really mentally ill' in a way which might conform to a gross stereotype of mental illness. Some were also stressing the belief that, if they had been ill, they had now changed, transformed or recovered, which of course they may have. Basically they were all stating that they were no different from those others to whom they planned to disclose the information.

The psychological mechanisms described here are distinct from those strategies described by subjects who planned to withhold information. Those strategies were consciously designed to manipulate information in order to avoid the problem of stigma.

(c) Subjects who Felt Information was Already Public

There were 12 subjects who thought that stigma existed but who also felt that they had no choice as to whether or not they could withhold or disclose information about their hospitalisation. They said that such information was already 'public'. There are two possible explanations for such responses. The first is that they would have withheld information if they perceived that such was possible. This indicates a feeling of powerlessness. The second is that they would have disclosed had they not felt that the information was already 'public'. This would indicate a lack of concern over the effects of such disclosure.

(d) Subjects who Indicated that there was No Stigma associated with Mental Illness and Psychiatric Hospitalisation

Eight subjects did not communicate that there was stigma attached to mental illness or psychiatric hospitalisation. One reason for this could be denial. Alternatively this may be a realistic appraisal of the

situation - particularly for the five Newfoundland subjects who all came from small 'outports'. This appraisal may reflect a lack of sophistication but it may also reflect an assumption that a small community would not reject one of its members. This must remain entirely speculative. Small communities may react in contrasting ways - either excluding and stigmatising deviants or accepting them because of familiarity.

Subjects' Characteristics and Strategies for Dealing with the Problem of Stigma

The categories in this chapter were subscribed to as follows:

TABLE 9:1 Subjects' Strategies concerning Stigma

Strategies	No of Subjects
(a)	36
(b)	44
(c)	12
(d)	8
Total	100

The two main strategies of planning to conceal (a) or to disclose (b) details of the psychiatric hospitalisation are considered here. The subjects who said they had no choice about dealing with this information as it was already 'public' (c) and those who did not communicate that stigma existed (d) are not included in the analysis here. This is because of the different interpretations which may be made about these responses. It should be noted, however, that whatever the interpretation, these subjects did not plan to actively conceal their psychiatric histories. This will be discussed below.

Despite findings in earlier chapters which indicated that more Newfoundland than Edinburgh subjects were anxious about becoming psychiatric patients and felt that they had been admitted against their wishes, subjects in the two locations were equally divided between the two strategies for dealing with the problem of stigma. This is presented in Table 9:2.

TABLE 9:2 Subjects' Strategies concerning Stigma by Location

Strategies	Location: Edinburgh	Newfoundland	Total
Conceal	18 (45.0%)	18 (45.0%)	36
Disclose	22 (55.0%)	22 (55.0%)	44
Total	40	40	80

$x^2 = 0$, df = 1, n.s.

Totals are less than 100 as those who felt the information was already public (c) and those who did not acknowledge the existence of stigma (d) are not included.

The subjects' strategies concerning stigma are compared with their conceptions of mental illness in Table 9:3. It appears that those describing mental illness as depression or anxiety only were more likely (65.0%) to plan to tell people they had been in a psychiatric facility than both those who described mental illness in terms of a negative stereotype only (45.5%) and those who described mental illnass as a wide range of conditions (55.9%). Those describing mental illness as a wide range of disorders were only slightly less likely to conceal this information (44.1%) than to disclose it. Subjects describing mental illness in terms of a stereotype only slightly more frequently said they planned to conceal their psychiatric histories (54.5%) than to disclose them (Table 9:3).

If, as was suggested in Chapter 5, subjects describing mental illness in terms of a stereotype only were those most anxious about becoming psychiatric patients themselves then it might have been expected that they would place a strong preference on concealing their psychiatric histories from the public. Conversely, those presenting mental illness as a broad range of disorders and an 'educated' and 'informed' view might have been expected to present an 'informed' view of psychiatric hospitalisation and planned to disclose their psychiatric histories. It seems, however, that it was the subjects who described mental illness as depression or anxiety only who were least concerned about the problem of stigma (Table 9:3).

TABLE 9:3 Subjects' Strategies concerning Stigma by Conceptions of Mental Illness

Strategies	Conceptions of Mental Illness: Stereotypes	Depression/ Anxiety	Both	Total
Conceal	12 (54.5%)	7 (35.0%)	15 (44.1%)	34
Disclose	10 (45.5%)	13 (65.0%)	19 (55.9%)	42
Total	22	20	34	76

$x^2 = 1.628$, df = 2, n.s.

Totals are less than 100 as those not coded on 'conceptions' and (c) or (d) on stigma are not included.

Little emerges when plans to deal with the problem of stigma are considered with the subjects' views on the aetiology of mental illness (Table 9:4).

TABLE 9:4 Subjects' Strategies concerning Stigma by Aetiological Themes (combined categories)

Strategies	Aetiological Themes: No Individual Blame (a) (b) and (c)	Individual Blame	Total
Conceal	11 (44.0%)	18 (42.9%)	29
Disclose	14 (56.0%)	24 (57.1%)	38
Total	25	42	67

$x^2 = .008$, df = 1, n.s.

Totals are less than 100 - not included are those not coded on 'aetiology', 'multi-category' subjects, and (c) and (d) on stigma

Table 9:5 shows a relationship significant at the 0.05 level between subjects' perceptions of the admission process and strategies concerning stigma. Subjects who saw themselves as 'help seekers' were most likely (68.4%) to tell people they had been in-patients in a psychiatric facility. Those who felt they had been compelled into their psychiatric admissions more frequently said they planned to conceal (65.5%) this information than to disclose it (34.6%) (Table 9:5). These findings generally indicate that those seeking help were least anxious about becoming psychiatric patients while those who felt compelled into their admission were most anxious. Of course it is possible too that subjects were resistant to hospitalisation partly because of a fear of stigma.

TABLE 9:5 Subjects' Strategies concerning Stigma by Perceptions of the Admission Process (combined categories)

Strategies	Perceptions of the Admission Process Help seeking	Compliant	Compelled	Total
Conceal	12 (31.6%)	7 (43.7%)	17 (65.4%)	36
Disclose	26 (68.4%)	9 (56.3%)	9 (34.6%)	44
Total	38	16	26	80

$x^2 = 7.209$, df = 2, $p < 0.05$

Totals are less than 100 as (c) and (d) on stigma are not included

As can be seen in Table 9:6, subjects who viewed their patient role as 'passive' were more likely (61.0%) to say they would tell people that they had been in a psychiatric hospital than those who described their patient role as 'active' (51.9%). The opposite might have been expected - that subjects 'active' in the patient role and presenting an 'informed' view of psychiatry would have also been more likely to disclose to others that they had been psychiatric patients.

TABLE 9:6 Subjects' Strategies concerning Stigma by Perceptions of the Patient Role (combined categories)

Strategies	Perceptions of the Patient Role Active	Passive	Total
Conceal	13 (48.1%)	16 (39.0%)	29
Disclose	14 (51.9%)	25 (61.0%)	39
Total	27	41	68

$x^2 = 0.553$, df = 1, n.s.

Totals are less than 100 as those not coded on roles and the ward milieu, those who wished to be discharged and (c) and (d) on stigma are not included

Education level is marginally related to views about the problem of stigma (Table 9:7). Subjects with some university or college education were most likely (63.6%) to plan to disclose the fact of their hospitalisation to others.

TABLE 9:7 Subjects' Strategies concerning Stigma by Education Level

Strategies	Education Level 0-9 years	10-13 years	University/ College	Total
Conceal	11 (44.0%)	17 (51.5%)	8 (36.4%)	36
Disclose	14 (56.0%)	16 (48.5%)	14 (63.6%)	44
Total	25	33	22	80

$x^2 = 1.24$, df = 2, n.s.

Totals are less than 100 in this and subsequent tables as (c) and (d) on stigma are not included.

Table 9:8 shows that older subjects - those over 44 - were most likely (68.4%) to say they would tell people they had been in-patients in a psychiatric facility.

TABLE 9:8 Subjects' Strategies concerning Stigma by Age

Strategies	Age Under 29	30-44 years	45 and above	Total
Conceal	17 (50.0%)	13 (48.1%)	6 (31.6%)	36
Disclose	17 (50.0%)	14 (51.9%)	13 (68.4%)	44
Total	34	27	19	80

$x^2 = 0.671$, df = 2, n.s.

An equal number of male subjects said they planned to conceal and disclose details of their hospitalisation (Table 9:9). Female subjects, however, were much more likely to tell people they had been in hospital (63.3%) than to hide this (36.7%). It is possible that some stigma is associated with simply admitting to any type of emotional problem. However, as the literature indicates, it may be more socially acceptable for women than for men to admit to having emotional problems and they are apparently more likely to discuss such problems with other people. They may be, therefore, less likely to be ashamed of having been hospitalised because of this. The findings for females in Table 9:9 are somewhat consistent with others in this research. Table 9:3 shows that subjects describing mental illness as depression or anxiety only were least concerned about stigma. Females (33.3%) subscribed to this category more than males (24.6%) (Table 5:6). Females admitted to hospital because of depression may be slightly less anxious generally about stigma than other types of psychiatric patient.

TABLE 9:9 Subjects' Strategies concerning Stigma by Sexual Status

Strategies	Sexual Status Female	Male	Total
Conceal	11 (36.7%)	25 (50.0%)	36
Disclose	19 (63.3%)	25 (50.0%)	44
Total	30	50	80

$x^2 = 1.347$, df = 1, n.s.

There was very little difference between married and unmarried subjects in relation to plans to deal with stigma (Table 9:10).

TABLE 9:10 Subjects' Strategies concerning Stigma by Marital Status

Strategies	Marital Status Unmarried	Married	Total
Conceal	21 (44.7%)	15 (45.5%)	36
Disclose	26 (55.3%)	18 (54.5%)	44
Total	47	33	80

$x^2 = 0.005$, df = 1, n.s.

Table 9:11 shows that non-manual workers were marginally less likely (42.4%) than manual workers (46.8%) to conceal that they had been psychiatric patients.

TABLE 9:11 Subjects' Strategies concerning Stigma by Occupational Status

Strategies	Occupational Status Non-manual	Manual	Total
Conceal	14 (42.4%)	22 (46.8%)	36
Disclose	19 (57.6%)	25 (53.2%)	44
Total	33	47	80

$x^2 = 0.205$, df = 1, n.s.

Subjects currently employed were slightly more likely (42.9%) than those not employed (47.4%) to plan to conceal their hospitalisation from others (Table 9:12). These differences are very small but may indicate that employed subjects felt a more immediate anxiety about being discriminated against at work because of their having been in hospital.

TABLE 9:12 Subjects' Strategies concerning Stigma by Employment Status

Strategies	Employment Status: Employed	Not Employed	Total
Conceal	18 (47.4%)	18 (42.9%)	36
Disclose	20 (52.6%)	24 (57.1%)	44
Total	38	42	80

$x^2 = 0.164$, df = 1, n.s.

As can be seen in Table 9:13 subjects with little or no 'experience' of psychiatry were more likely (61.1%) than those with such experience (50.0%) to tell people they had been in hospital. Again the differences are small but it may be that those who had had psychiatric out-patient treatment themselves or knew of friends or relatives who had had this or in-patient treatment had experienced or seen evidence of stigma. This may have influenced their plans regarding their current situation more than those with no experience.

TABLE 9:13 Subjects' Strategies concerning Stigma by Experience of Psychiatry

Strategies	Experience of Psychiatry: Low	High	Total
Conceal	14 (38.9%)	22 (50.0%)	36
Disclose	22 (61.1%)	22 (50.0%)	44
Total	36	44	80

$x^2 = 0.987$, df = n.s.

The subjects most likely to plan to disclose details of their hospitalisation, then, were those describing mental illness as depression or anxiety only, those who perceived themselves as 'help seekers' in the admission process and those who described their patient role as 'passive'. Subjects with university or college education, over 44 years of age, females and those with little psychiatric experience were also most likely to tell people they had been in hospital. Non-manual workers were slightly more likely to disclose this information than were manual workers but those currently employed were more likely to conceal this.

Having resources appears to be related to plans about stigma somewhat less than to other topics in this research. Other factors seem to be more influential in whether or not the subjects planned to conceal or disclose that they had been patients in a psychiatric hospital. Most notably these were their attitudes to the admission process and how they conceptualised mental illness.

Conclusion

The central focus of this chapter has been the subjects' views about the stigma associated with mental illness and psychiatric hospitalisation and their plans to deal with this issue in relation to their own hospitalisation.

The subjects responded in four ways to the questions relating to stigma. The two largest groups said they either planned to conceal or disclose their histories. A small number said they had no choice in the matter as this information was already public and a few did not acknowledge the existence of stigma. The group who actively planned to

conceal the fact of their hospitalisation comprised only slightly more than a third of the sample. This included telling no one or telling a few trusted people. Some planned to conceal the nature of the hospital they had been admitted to or the type of problem which had precipitated their hospital admission.

It would appear, then, that while these subjects thought that people were often discriminated against once known as former psychiatric patients, most were not concerned to the extent that they would hide the fact that they themselves had been psychiatric patients.

Critics of a narrow version of labelling theory, as was mentioned above, suggest that patients may deal differently with the label of mental illness. These subjects appeared to do this both in relation to their own self identities and in relation to telling others about psychiatric hospitalisation. The strategies advanced by those saying they would tell people about their hospitalisation demonstrates this. These included an 'educational' stance, whereby they planned to disclose the beneficial aspects of hospitalisation and to reveal the 'truth' about and 'normality' of psychiatric patients. Essentially they planned to normalise the experience and thus reduce the likelihood of being thought of negatively. Some subjects planned to confront other people, leaving it to the others to accept or reject them. Other subjects said they simply hoped people would understand and not stigmatise them.

It might have been expected that subjects who described mental illness as a wide range of disorders (and whom it was suggested were less anxious about becoming psychiatric patients) would have been most likely to disclose to others that they had been patients in a psychiatric

hospital. This would be consistent with advancing an 'informed' and 'educated' view of psychiatry. In fact it was the group of subjects who described mental illness as a neurotic disorder - as depression or anxiety only - who were most likely to disclose this information. It seems likely that these subjects, having not thought of 'the mentally ill' in terms of a negative stereotype at all, did not expect others to do so either.

Similarly the subjects who described their patient role as passive were more likely to disclose that they had been in hospital than were those who described their patient role as 'active'. Again it might have been expected that 'active' subjects, advancing an 'informed' psychiatric view would have been most likely to disclose details of their hospitalisation. However it appears that many of the subjects who described their role as passive generally conformed to a sick role perspective. Their responses to telling people about their hospitalisation may have been little different from what they would do on being discharged from a general medical hospital. Of course many of these were also suffering from depression and described mental illness in terms of depression only. Both these groups, then, were most likely to disclose that they had been in hospital.

It was also seen that a higher proportion of female subjects than males planned to tell people of their hospitalisation. This reflects the findings for 'conceptions' and 'patient role perception'. In addition it was suggested that it may be more culturally appropriate for women to be seen to be suffering from emotional problems. This is suggested in the literature which also finds that women are more likely than men to discuss such problems with other people.

The relationship which was most apparent was that between attitudes to the admission process and plans regarding stigma. Those who saw themselves as 'help seekers' were much more likely than those who felt compelled into their admission to say they would tell people they had been in hospital. Of course part of the reluctance regarding the admission may have stemmed from a fear of stigma. However their responses to questions concerning why people might not seek help did not indicate this. While a number said they had been anxious about stigma prior to hospitalisation, this did not appear to have influenced their actions.

Following from the analysis in Chapter 7 the parasuicides and out-patients were included in the consideration of the three categories of perceptions of the admission process. It seems, however, that the parasuicides as a group were far more likely to say they would conceal that they had been in hospital. Only a small number (6) said they would tell people this. It may be that these subjects feared the additional problem of being thought of negatively because of their suicide attempt, although they did not explicitly state this.

Other subjects most likely to disclose that they had been in hospital were those with university or college education who were also most likely to see themselves as 'help seekers' in the admission process and those over 44 years of age.

Overall, however, having resources does not appear to have been influential in whether or not the subjects planned to tell people they had been in hospital. Non-manual workers were marginally more likely than manual workers to plan to disclose details. But those currently in employment were more likely to conceal this. It was suggested that

perhaps subjects in employment were immediately concerned about being discriminated against at work.

Those with little or no psychiatric experience were more likely than those with such experience to plan to tell people they had been in hospital. It was suggested that some subjects who had known others who had been patients in psychiatric hospitals had heard of actual incidents of discrimination and this may have influenced their plans for their own situations.

If a psychiatric/sick role perspective is most relevant in explaining the experience of becoming a psychiatric patient, then it would have been expected that the subjects would not be concerned about others knowing of their psychiatric histories. Indeed a majority in this sample, in not planning to actively conceal such information, appear to fit with these expectations.

Only a minority appeared to comply with what a labelling perspective would predict - feeling particularly anxious about being identified as former patients and planning to conceal this information from others.

Finally, it may be that the type of hospital which these subjects were admitted to was an important consideration in the decision to disclose or withhold information. Most of those Newfoundland subjects who planned to hide information were patients in Waterford Hospital. It is likely that: (a) there is more stigma associated with having been a patient in Waterford Hospital - the Provincial Psychiatric Hospital - than with having been a patient in the Health Sciences Centre Psychiatric Unit - a unit in a general hospital - this has a historical basis; and (b) having been a patient in a psychiatric unit in a general hospital

also means that it is possible to hide information about the type of unit or ward either by lying or by not specifying, assuming that others will think it was a medical unit.

CHAPTER 10

Conclusion and Policy Implications

Conclusion

This thesis has considered the process of becoming a psychiatric patient from the perspective of patients themselves. It has considered their responses to several issues related to this process, namely (i) their self-conceptions and their ideas about the nature of mental illness and the characteristics of the 'mentally ill'; (ii) their beliefs and knowledge about the aetiology of mental illness; (iii) their perceptions of the process leading to their psychiatric hospitalisation; (iv) their expectations of the hospital and their understanding of their role as psychiatric patient, and (v) their views on the stigma of mental illness and psychiatric hospitalisation and their plans to deal with this.

As was seen in Chapters 5 - 9 there was a certain observable relationship between the views expressed on different topics by the subjects in this research. First, those who described the admission process as one in which they had been seeking help were considerably more likely also to have described mental illness as a broad range of disorders and less likely to use stereotypes only than either those who merely acquiesced in the admission process or than those who felt compelled into the admission. Both of these views appear to reflect a lack of anxiety about becoming a psychiatric patient and about being identified as mentally ill. These subjects, of whom there were 23, were apparently expressing an acceptance of, or were even actively embracing, a psychiatric world view. They were more than merely 'willing' - in the sense of not being reluctant - patients.

Second, consistent with these findings, attitudes to the admission process were clearly related to views on stigma. 'Help-seekers' were considerably more likely to plan to tell people they had been in hospital. This was despite acknowledging the existence of stigma and even the possibility of being stigmatised themselves. Stressing the benefits of psychiatric treatment for themselves, these subjects did not wish to negate this experience by hiding their histories from other people.

By way of contrast, those subjects who felt they had been compelled into a psychiatric admission were more likely than others to plan to conceal the fact that they had been in hospital or to limit the numbers who knew of this. That these two factors were related is not surprising. These subjects may have been particularly anxious about stigma prior to their admission and resistant to hospitalisation because of this. In addition some also felt that there was a risk attached to others knowing that they had been coerced into the admissions. Such information might reinforce others' negative attitudes and therefore increase the possibility of discrimination.

Those describing mental illness as a wide range of disorders might have been expected to be most likely as well to disclose the fact of their hospitalisation. In discussing the nature of mental illness and the mentally ill, they advanced a view which would appear to approximate that of the psychiatric profession. They appeared less concerned than some other subjects about the meaning of becoming a psychiatric patient and about being considered as 'mentally ill'. In general they presented an 'educated' and 'informed' view of psychiatry. It would have been consistent with these views if they had also planned to tell

people they had been in hospital. But this group were only slightly less likely to plan to conceal such information as to disclose it. And those who described the mentally ill in terms of a stereotype only - whom it was suggested were most anxious about becoming psychiatric patients and being labelled as mentally ill - were only slightly more likely to plan to conceal the fact of their hospitalisation than to disclose it. The group most likely to disclose information about their hospitalisation were those who described mental illness as depression or anxiety - as a neurotic disorder. This at first appears surprising. It is likely, however, that a fear of being stigmatised is widespread. Negative attitudes were acknowledged as existing by those presenting mental illness as a wide range of disorders. In their descriptions they included the mentally ill as unpredictable, bizarre and perhaps dangerous. They were therefore aware of the possibility that other people might associate such behaviours with their condition and so look upon psychiatric hospitalisation in a negative light. The group of subjects describing mental illness only in terms of a neurotic disorder - seeing mental illness in a benign way - would also expect other people to think of mental illness in a similar way. Therefore, although they acknowledged that stigma existed, they would not anticipate being thought of as bizarre or dangerous because they had been in a psychiatric hospital.

The relationship between the subjects' views on their patient role, their beliefs about the aetiology of mental illness and these three variables was less clear. Those seeing their patient role as 'active' were considerably less likely to have described the mentally ill in terms of a negative stereotype only and more likely to describe mental

illness as a broad range of disorders. Again this reflects an acceptance of an 'informed' psychiatric view. However, little else fitted expected patterns.

Those who described their patient role as active were much less likely to have either felt compliant in the admission process or to have felt compelled into the admission - as would have been expected from the other findings. Again this indicates an informed view. Those seeing their role as active had somehow been educated into the accepted psychiatric view of the treatment situation. This to some extent depended on which ward they had been admitted to and to what extent this view had been made explicit. It also seemed to indicate receptiveness to such a view.

However, a considerable proportion of those who saw their patient role as passive also described themselves as help seekers. Subjects seeing their role as passive were not, then, necessarily resistant to psychiatric treatment. A medical view of the patient role was dominant for a majority of subjects in this research. This is not surprising given that they had never previously been patients in a psychiatric facility. Most people's entire experience of medicine involves seeking help for a problem and accepting the treatment offered without actively participating in the therapeutic process. For these subjects, then, actively seeking help but at the same time viewing the patient role as passive were not contradictory.

The relationship between the issue of stigma and role perception is similar. Those seeing their role as active were only slightly more likely to plan to disclose than to conceal information about their hospitalisation. Those describing their role as passive were much more

likely to disclose such information than to conceal it. These findings are not inconsistent with those comparing conceptions of mental illness and plans relating to stigma. A large number of those seeing their role as passive were also those who were themselves depressed and described mental illness in terms only of depression or anxiety. They did not associate negative stereotypes with 'the mentally ill' and probably did not expect other people to do so. These subjects entered the psychiatric hospital with a view similar to that which they would have on entering a general medical hospital.

Views expressed on the aetiology of mental illness, as was seen above, did not clearly relate to any of the other views expressed by the subjects in this research. It was expected that those attaching blame to the individual for causing his or her illness might have different views on other topics from those who did not attach such blame. To some extent this was confused because some subjects were apparently expressing their beliefs about what caused their own illness or problem while others apparently discussed the topic in the abstract. This issue was particularly confused by the existence in the sample of a large number of subjects with alcohol dependence problems. Many of these had themselves been blamed by family or friends for causing their own condition. This view on aetiology would probably have influenced their responses on this subject no matter what their ideas on the other issues dealt with by this research.

Various patient characteristics were considered in relation to the topics addressed in this thesis. These are summarised in Chapters 5 - 9. What emerged was largely consistent with the general literature in this area. A higher proportion of those subjects advancing an 'informed'

view had the advantage of being in employment, being of non-manual status or having some university or college education.

One variable considered which was not clearly related to attitudes was that of experience of psychiatry. From the literature on attitudes and help seeking behaviour, it seems that such experience is likely to lead to more 'liberal' attitudes. But for these subjects such experience did not appear to have been influential in this direction as a whole. The subjects' individual explanations, however, tend to indicate that experience of psychiatry can work in different ways. It can lead to acceptance of a psychiatric view and liberal attitudes generally. Conversely, it can result in negative attitudes. In some cases it seems to have resulted in an anxiety about being labelled as mentally ill and a fear of the consequences of this. Some of this appears to have depended on the nature of the experience. Some subjects knew of other people who had themselves reacted in a critical fashion to being in psychiatric hospitals. They had also heard of instances of people being stigmatised after being discharged from psychiatric hospitals. Such 'experience' seems likely to influence negative attitudes and resistance. Conversely, knowing of other people's positive experiences in psychiatric hospitals likely influences acceptance of psychiatry and positive attitudes.

Finally, it appeared overall that a much wider variety of behaviours and conditions were associated with mental illness or at least with psychiatric disorder than would have been suggested by the literature on attitudes towards mental illness. Many of these subjects called a wide variety of symptoms and behaviours 'mental illness' and indicated that some conditions such as 'nerves', although not necessarily 'mental illness' were problems in need of psychiatric

attention. Because the subjects themselves were psychiatric patients and in the situation of dealing with a potentially stigmatising label of mental illness, comparisons with the attitudes of the public must remain tentative. However, it may be that the threshold for recognising behaviour as mental illness, in practice, is lower than is normally argued in the literature and attitudes closer to that of the psychiatric profession.

While the process of becoming a psychiatric patient has been considered in detail in the literature, there has been little investigation of this from the viewpoint of patients themselves. The labelling and psychiatric/sick role perspectives advance different views on this process, but their applicability in terms of the subjective experience of patients being admitted to hospital has rarely been considered. The sample may not be representative of all patients admitted to psychiatric hospitals. However, conclusions may be made about the relative applicability of the labelling and psychiatric/sick role perspectives to these subjects' experiences. This thesis has investigated some of the issues arising from these perspectives.

If labelling theory, as advanced by Scheff (1966) is applicable to the experience of becoming a psychiatric patient, certain responses would be expected from the subjects in this research. As patients being admitted to a psychiatric facility they would be expected: to be resistant to hospitalisation; to think of mental illness and the mentally ill only in a negative way and in terms of stereotypes - characterised by unpredictability and bizarre behaviour - and also in coming to accept the mental illness label themselves, to think of their

own condition negatively; to be resistant to treatment; to fear the consequences of psychiatric hospitalisation - being anxious about the stigma associated with this and anticipating being discriminated against if they revealed a psychiatric history.

On the other hand if a psychiatric/sick role perspective is more applicable to the experience of becoming a psychiatric patient then these subjects would be more likely: to have sought treatment having recognised that they had problems in need of attention; not to think of mental illness, the mentally ill or themselves in a negative way; to accept the treatment offered, and not to fear being discriminated against as a result of having been hospitalised for a psychiatric condition.

It is apparent that a narrow version of labelling theory cannot adequately explain these subjects' experiences and understanding of being hospitalised - given the high proportion who apparently sought help and/or were admitted to hospital willingly. These comprised 67% of the sample. (Both those who said they sought help and those who felt generally compliant but not opposed to the admission.) Similarly a high proportion (63%) either saw mental illness in a benign way or presented a view which might be expected from members of the psychiatric profession themselves. In addition practically all of the subjects in this research indicated that they would co-operate in their treatment - whether they saw their role as 'active' or 'passive'. Some dissatisfaction was expressed regarding the hospitals or wards but this did not mean overall resistance. Finally, when the issue of stigma was addressed, a minority (36%) said they would actively conceal that they had been in a psychiatric facility.

As was discussed in Chapter 2, labelling theory has been criticised for its deterministic view of the labellee - for its assumption that he or she will accept a deviant identity once labelled by others. A 'broader' version of labelling theory is advanced by Plummer (1979) and by others critical from the same or a similar standpoint which would allow for different responses and interpretations on the part of the labellee to the label of mental illness. The findings in the present research are consistent with this. Patients, it seems, do not necessarily see themselves in a negative way. These subjects appear to have responded in a variety of ways to the mental illness label. Each of these ways, however, indicates an attempt to maintain a positive view of self.

On the other hand a psychiatric/sick role perspective does not completely explain the experience of becoming a psychiatric patient. Some, albeit a minority, were unwilling to be admitted to hospital. In addition that 36% were concerned enough about the stigma associated with mental illness and psychiatric hospitalisation to plan to conceal their histories testifies against a narrow sick role perspective as formulated by Parsons (1951). A major criticism of sick role theory as it applies to psychiatry was made by Freidson (1970), who pointed out that the problem of stigma was not adequately considered.

It was suggested in Chapter 2 that labelling theory might be applicable to 'unwilling' patients and psychiatric/sick role perspectives to 'willing' patients (following from Whitt, Meile et al. who suggested that these two contrasting views might be applicable to involuntary and voluntary patients respectively). Overall, however, there is little evidence to support labelling theory - and a narrow

version in particular. If the three central variables in this research are considered - perceptions of the admission process, conceptions of mental illness and plans to deal with the issue of stigma - only six subjects clearly fitted with labelling theory's predictions. That is six had in common that: (a) they felt they were 'unwilling' patients; (b) they described mental illness in terms of a negative stereotype only, and (c) they actively planned to conceal the fact of their hospitalisation. Two of these were Edinburgh subjects and four were from Newfoundland. Although it might not have been expected, five of these had been admitted to hospital on an informal basis. An informal admission status, then, does not necessarily reflect willingness to be admitted to hospital or to accept psychiatric treatment.

On the other hand 32 subjects (21 from Edinburgh and 11 from Newfoundland): (a) said they had entered hospital willingly; (b) described mental illness either in an 'informed' way or in a way not implying socially unacceptable behaviours or conditions, and (c) did not plan to conceal the fact of their hospitalisation. That this percentage of the sample fits with what a sick role perspective would predict lends support to that perspective as it applies to the experience of becoming a psychiatric patient. This was particularly notable in the Edinburgh situation - the subjects with these features in common comprising 42% of that part of the sample.

This group of 32 subjects had a high level of education, were older and more were currently in employment when compared to the rest of the sample. These factors likely indicate feelings of being in control of the situation and a lack of anxiety about being admitted to a psychiatric

facility.

That sick role theory has been criticised because of its failure to consider the issue of the stigma associated with psychiatric hospitalisation needs to be highlighted. While a minority (36%) said they would actively conceal their hospitalisation, this still represents considerable recognition of the possibility of discrimination because of such a history. This should not simply be taken as a negative attitude towards psychiatry or as an 'uninformed' view. It is likely that former psychiatric patients are sometimes discriminated against in some situations. It was seen that those who advanced a 'psychiatric view' in describing mental illness as a wide range of disorders were almost as likely to conceal their psychiatric histories as to disclose them. People may, then, hold an 'informed' and 'educated' view of psychiatry and psychiatric illness but may not trust other people to share these same attitudes. On this basis they may expect others possibly to discriminate against them. Therefore, not wishing to risk such discrimination patients may plan to conceal that they had been hospitalised in psychiatric facilities.

To a lesser extent sick role perspective, in assuming that people will seek help for problems, does not take into account the anxiety which probably is associated with seeking help for psychiatric problems - and probably the general anxiety associated with entering hospital for any problem. In the case of psychiatric patients, this anxiety of admission to hospital is likely exacerbated by anxiety about stigma.

One final point, mentioned in Chapter 2 in relation to the applicability of labelling theory, concerns the changes which have taken place since Scheff published his initial argument in terms of

legislation regarding commitment to hospital, of conditions within psychiatric hospitals and of the length of stay in such facilities.

First, the percentage of patients admitted on a compulsory or involuntary basis is comparatively small compared to the number admitted on an informal or voluntary basis. This contrasts with the situation described by Scheff. Practically all of the subjects in this research had been admitted on a voluntary basis. Labelling theory's applicability to this situation is probably questionable on this basis alone. Second, conditions within hospitals have changed since the 1960s. While old images of psychiatric hospitals remain - and this was found among some subjects in this research - others were apparently aware of contemporary conditions. Much of this awareness had come from direct experience. Many had visited friends or relatives in psychiatric facilities. Still others were aware of changes from various media presentations on psychiatry and psychiatric treatment. Finally, the average length of stay in psychiatric facilities is now fairly short. These subjects were generally told on entering hospital that they were expected to be in for quite a short period of time. Entering a psychiatric patient role, then, was recognised as a temporary state. This probably facilitates the ability to deal in different ways with the mental illness label and possibly also with the problem of stigma. Such a label may be more likely to be rejected or reinterpreted as non-threatening given the expectation of a short period of hospitalisation. Similarly a short stay may be presented to the outside world as such - as a temporary respite - and not necessarily as an indication of a serious condition. These factors in themselves cast some doubt on the general validity of

Scheff's labelling perspective to the experience of becoming a psychiatric patient.

This thesis, then, has found that the psychiatric/sick role perspective more adequately explains these subjects' experiences of becoming a psychiatric patient than does a narrow version of the labelling perspective. It has also contributed to an underinvestigated area - that of the psychiatric patient's own view.

Policy Implications

As was seen in Chapter 2, several factors can influence help seeking. From these subjects' responses it appears that knowledge, or the lack of it, accessibility, feelings of embarrassment or shame and the fear of stigma were probably somewhat influential in determining whether they initially sought and pursued help.

However, because of the apparently central role of the GP or family doctor in recognising and identifying psychiatric disorders, it is difficult to assess from these subjects' responses if they themselves would have recognised that their problems needed psychiatric attention without such an opinion. A few subjects reported that they did. Without fully knowing the processes involved in problem identification it is difficult to conclude that easier access, for example, to a 'drop-in' centre would have been a viable alternative. However for the group of 'help seekers' who were apparently pressurised by significant others and who delayed seeking help, attempting to deal with the problem by themselves, perhaps a less stigmatising treatment centre and easier access to such a facility offering advice might have helped avoid some of these delays. It is apparent from these and other subjects'

responses that the fear of the stigma associated with the psychiatric hospital itself was a factor in influencing decisions whether or not to seek help. In addition there could be arrangements for psychiatric treatment in the community in mental health centres. The development of such alternatives which could offer treatment, advice and education has been recommended by the Lothian Joint Working Party on Mental Health Services (1986).

A fear of stigma associated with the psychiatric hospital itself was particularly notable in the responses of some subjects who had been admitted to Waterford Hospital. It is apparent that the title of the hospital and its associations as the Provincial psychiatric hospital - still commonly referred to as 'the Mental' - resulted in a fear of the stereotypes associated with the traditional asylum as well as a fear of being stigmatised because of having been a patient in such an institution. It was also seen that the subjects in Newfoundland most likely to have planned to withhold information about their hospitalisation were patients in Waterford Hospital. It was thought that this was partly because of its historical reputation and partly because it appeared possible to hide information about having been treated in a psychiatric facility if this were located in a general hospital. In addition, as was mentioned in Chapter 4, people referred to Waterford Hospital may live at some considerable distance from the hospital. Admission to that hospital may, then, involve a feeling of exclusion from the community. Waterford Hospital also had a relatively high rate of compulsory admissions. Both these factors may tend to exacerbate feelings of being stigmatised as a result of such a psychiatric admission.

As was seen in Chapter 4, the development of psychiatric units in

general hospitals in Newfoundland meant that people were excluded from the communities in which they lived to a lesser extent than previously. As Hoenig et al (1982) point out, the introduction of the Newfoundland Mental Health Act 1971 meant that voluntary admissions could now be treated in general hospitals closer to home. (1) The statistics in Chapter 3 indicate that this does not always happen. In addition, a number of the subjects in this research had been sent from communities at some distance from St John's. However, the increasing trend in this direction means that feelings of exclusion and the resultant stigma might be ameliorated.

Although the Royal Edinburgh Hospital is in the centre of a city it is, from some subjects' responses, probably seen as apart and isolated from the community which it serves. Evidence of exclusion was seen in their feelings about being stigmatised and some of the reluctance to agree to a psychiatric admission. The size of psychiatric hospitals is probably also important. They tend to be large and probably intimidating. As in Newfoundland, the stereotyped view of the psychiatric hospital as an 'asylum' was prevalent among many Edinburgh subjects' expectations.

Psychiatric units in general hospitals are an alternative to large psychiatric facilities. The advantages and disadvantages of these are topics of current debate. The Department of Health and Social Security (1975) report - Better Services for the Mentally Ill - points

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(1) The Act also allowed for committed patients to be treated in any facility but due to accommodation problems the majority of patients admitted on an involuntary basis are still diverted to Waterford Hospital

out the problem of balancing the advantages of the psychiatric unit in the general hospital against those of the large single facility with its wide range of services. However, if the psychiatric hospital is to continue as a major treatment resource, then the problems of isolation, exclusion, accessibility and stigma need to be addressed.

The importance of accessibility has also been stressed in Mental Health in Focus (1985) [2] which suggests alternatives such as 'open-door' or 'walk-in' facilities as well as mental health advice and treatment centres. As was suggested above, it cannot be concluded that the subjects in this research would have all benefitted from the existence of such facilities. However, they may serve several functions, one of which, previously mentioned, may be in getting people to professional attention without the delays which some of these subjects reported, and presumably the disruption and strain which this placed on other people. In addition, such facilities could help reduce the overall fear of psychiatry by providing an easily accessible link between the community and specialist services. The participation of psychiatric professionals in this and in the area of providing information to the public could aid in the needed opening-up of psychiatry to the community at large.

What clearly emerged from these subjects' views was that a much wider variety of behaviour and conditions appeared overall to be associated with mental illness, or at least with a general view of psychiatric disorder (given the problematic use of the term mental

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(2) This is a 'Report on the Mental Health Services for Adults in Scotland' of a planning group set up by the Advisory Council on Social Work and the Scottish Health Service Planning Council

illness) than would have been suggested by the literature on attitudes towards mental illness. As was discussed in Chapters 2 and 5, it may be that people in general do in fact hold a view closer to that of the psychiatric profession than the literature would suggest. Nevertheless the need for further education and for facilitating communication at the community level is apparent.

Many of these subjects reported that they did not discuss their problems outside the household and others had not apparently even discussed these with family members or friends. It seemed that fear and embarrassment played an important part in this. Similarly the fear of being stigmatised was obviously based on a fear that other people would not understand the reasons why they were hospitalised, or the nature of their problems or illnesses. While it appears that people's attitudes may not be as stereotyped as is commonly supposed, these stereotypes do exist. This was seen not only in these subjects' views on the nature of 'mental illness', but also in their fears and expectations on being admitted to hospital.

The strategies described by the subjects in terms of 'educating' and 'confronting' others to deal with the problem of stigma might be successful at the individual level. Nevertheless it is obvious that more widespread information needs to be disseminated in a way which will help reduce the general public view of stereotypes of mental illness. However, attitudes seem to be resistant to change. There is a considerable amount of discussion about this issue but the best way to approach it is not clear.

The priorities of education proposed in Mental Health in Focus (1985) are: that people should be given information to help them cope

and deal with mental health problems; that people working in this area should aim to help change attitudes and behaviour, for example by becoming involved in community projects and by focussing on everyday problems; that education in schools and places of employment should be encouraged, and that there should be more education in professional training. Finally, the importance of media coverage on the topic is stressed. Although the white paper - Better Services for the Mentally Ill (1975) - is not as positive about the possibilities of changing public attitudes, it generally emphasises the importance of the attitudes and behaviour of a variety of people working in services in which they come in contact with former psychiatric patients.

Providing education in these general areas could be beneficial. More specifically the current research suggests three areas where education could be targeted and information improved. These are at the general community level, to patients in the psychiatric facility itself and from GPs to patients at the primary care stage.

As was seen from these subjects' responses, it appears that people are quite able to distinguish between fact and fiction. What is notable was that they tended to stress the fictional nature of media presentations and although very few could remember details of factual presentations they were probably open to sympathetic and intelligent portrayals of psychiatric problems and their treatment. However, as with the general issue of disseminating information to the public, the best way to change attitudes is not clear. Questions arise as to how best to make and present programmes in the media and who to direct them at.

The role of the family doctor was seen to be central in referring

people to specialist services. This is obviously a crucial area for education and improved communication. As was suggested in Chapter 2, in the discussion of Goldberg and Huxley (1980), there is apparently considerable variation among GPs in the perception and recognition of psychiatric disorder. Mental Health in Focus (1985) stresses the need for improvement in this area and the importance of GP training.

Although the GP or family doctor appears to have been effective in referring these subjects to psychiatric specialists, many subjects were generally unaware about the type of facility they were being referred to, which area of the hospital, or on what basis they were being sent to particular wards. Because of the nature of the referral system, GPs themselves may not always be aware of the exact nature of the facilities to which they refer patients or the type of treatment they will receive there. However, patients need to be more aware of what will happen to them. GPs could become more familiar with what happens within psychiatric hospitals and they could also communicate such information to patients being referred to psychiatry. These are aspects which could be focussed on more in GP training.

A particular problem seems to have emerged for those subjects admitted to hospital because of drinking problems. As was seen, many of these subjects were among those who delayed seeking help. From these subjects' responses, it appears that this is partly because of ambivalence regarding alcohol dependence and mental illness. Many felt reluctant to admit themselves to hospital because, although they considered that they had a problem, they did not identify this as a psychiatric disorder. Moreover, some dissatisfaction was expressed

by subjects who found themselves in acute psychiatric wards when they had expected to be in separate units for addiction problems. The reasons for this had apparently never been made explicit to these subjects. Communication could obviously be encouraged in these matters, both at the GP level, where identification of alcohol related problems could also be facilitated, and when the individual is first seen at the psychiatric facility. In addition, community health centres, mentioned earlier, may possibly help in encouraging early help seeking for people with these types of problems.

Finally, it appears that information could be improved at the ward level. This would appear to be a general problem facing many patients in all branches of medicine. For example, although the people questioned on their attitudes to treatment in a research project of the Royal Commission on the National Health Service (Patients' Attitudes to the Hospital Service 1978) were generally satisfied with most aspects of their experience, lack of communication and lack of information was pointed to as a problem for some. In the current research this was not only reported as a problem by some, but also apparently is indicated in these subjects' understanding of their patient role.

The level of patient participation in medicine varies according to the condition or problem for which the patient is being treated and the type of treatment involved. In any type of psychiatric treatment, however, some active participation on the part of patients themselves would seem to be desirable. Patients may benefit in this by being aware of the features of the psychiatric patient role. A small number of subjects in this research appeared to be fairly knowledgeable about this role. Where such awareness existed it seems to have resulted from

their having been explicitly told about what to expect either by other people who had been in hospital or by the psychiatric staff. However at the ward level, such 'education' does not appear to have been consistent. This was seen in the large number of subjects who described and/or wished their patient role to be passive. Dissatisfaction for these subjects did not necessarily result from holding such a perspective but it is considered that this is a potential source of discontent, or at least communication problems in therapy. Of course, patients may become aware of the nature of psychiatric treatment after a few days in hospital and this issue might not be problematic at this stage. However, this does not negate the anxiety which they may have because of a lack of information when first admitted to hospital. It may therefore be advantageous, and possibly less confusing, if new patients are informed about the nature of the psychiatric patient role through consistently applied programmes which introduce them to the methods of the therapeutic community as soon as possible after their arrival in hospital.

Although the records showed that practically all of the subjects in this research had been admitted to hospital on an informal or voluntary basis there was, as was seen in Chapter 7, a large number who essentially felt they had been coerced into their psychiatric admission. Obviously the meaning of a voluntary or informal status varies depending on the context of the admission and the process leading to it. In some instances it seems that 'voluntary' patients agree to admit themselves to hospital only because of irresistable pressures which may even take the form of threats to take compulsory measures. It may be of some benefit in particular to such 'voluntary'

but apparently reluctant patients that reassurance and information about the psychiatric hospital and psychiatric treatment be made fully available when the patient first arrives at hospital.

The subjects in this research who expressed general dissatisfaction about being in hospital (although only a small minority) tended also to be among those who considered that they had been coerced into their psychiatric admission. This dissatisfaction took the form of being highly critical of the hospital, of not wishing to receive treatment and of planning to be discharged. Increased communication of the type described above may help to alleviate such resistance to treatment and to reduce confusion.

It may be that the psychiatric staff themselves are not always fully aware of the extent to which some patients with an official 'voluntary' status feel they have been coerced into a psychiatric admission. In this and other areas increased awareness on the part of the staff of patients' subjective understanding of hospitalisation may help to facilitate a successful therapeutic environment.

Of course many patients on being admitted to hospital may not be amenable to or receptive to detailed information. While the subjects in this research were not disoriented and were aware of their surroundings and what was happening around them, not all patients are in such a condition. As was seen in Chapter 3, a considerable percentage of first admission patients were not amenable to the type of interview required for this research. Many were too disoriented or disturbed and presumably this reflects the general pattern of patients admitted to psychiatric facilities. Nevertheless it would seem desirable not only to reassure but also to inform the new patient

as much as possible in order to help the problem of resistance and to alleviate anxieties.

Not only the desirability of patients playing an active role in psychotherapy, the value of the psychiatric hospital as an asylum in the literal sense must not be under-estimated. Many of these subjects expressed relief simply at having been hospitalised and felt that this in itself had been therapeutic. Indeed for some withdrawing from stressful situations for a time may have been adequate in itself.

Much has been done to show the harmful effects of being a patient in a psychiatric hospital. Not only are patients seen to be adversely affected because of being labelled mentally ill, but the harmful effects of adjusting to hospitalisation and the effects of institutionalisation are also pointed to. Yet if, as the evidence from this research suggests, patients do not necessarily perceive themselves in terms of a mental illness stereotype and do not behave according to this, and if they regard their stay in hospital as short, as a respite, then the psychiatric hospital for acute psychiatric disorders may not be as harmful as is sometimes argued. That is not to say that large psychiatric institutions need be the only facility, or even the best facility to offer a function as a retreat or a respite. These subjects in this research who were patients in the Health Sciences Centre Psychiatric Unit offered similar views in terms of retreating from stressful situations. Psychiatric units in general hospitals could possibly provide a similar function. The likelihood of being stigmatised because of having been a patient in such a facility would possibly be less. Community mental health centres could be an alternative means of providing respite with a

reduced likelihood of stigmatisation.

Psychiatric patients' experience of hospitalisation is an under-investigated area and as a consequence this is not sufficiently considered by policy-makers and the providers of services. Research in this area is not only of academic interest but also of considerable practical value in a consideration of the efficiency and quality of care.

APPENDIX I

Interview Schedule

1. Can you tell me your date of birth?

2. (M/F)

3. Can you tell me your occupation? Is that the job you've always done? What did you do before that?

4. Are you married?

5. How many children have you? And what ages are they?

6. Can you tell me what age you were when you left school? Did you have any qualifications then? Did you get any qualifications after that?

7. Where is it you stay? Is that your own house/Is that a council house?

8. (Informal/Compulsory, which section?)

9. (Go over known date of admission, e.g.) Well you came here on ... is that right? And were you referred by your GP or how did you come here? (Ask for details of entire referral process. How long prior to admission they knew about it? Did they have much time to think about it? Did they discuss it with anyone? How many days had they been on the ward? General details and what has happened since then.)

.....

10. Can you tell me what your first impressions of this place were? (If applicable) And after that what did you think? How would you describe the place?

11. Does it seem in any way to you to be like a general hospital? How is it different?

12. What about the ward/unit itself, can you describe it to me, what you see going on ... what the atmosphere's like?

13. Did you have any expectations of what it would be like here before you came?

14. (In your opinion) what would you say the general purpose of the hospital is? Do you think people come here for treatment for problems or for a rest and escape or what? What do you think the main reason is?

15. (In your opinion) are the people in this hospital ill in some way? What would you say are the main problems which bring people to places like this?

16. Do you think there are people outside the hospital with the same sort of problems but don't come for help? Why do you think they don't come? Are those the main reasons?

17. How much do you know about the other people on the ward, have you talked to them?

18. In your opinion, is it good for them to be here?

19. Everyone has problems, personal problems of one sort or another, but don't always go to psychiatrists, seek psychiatric help. Can I ask you your opinion on the sorts of problems people might take to other professionals and the types of problems they could deal with, say if they were not going for psychiatric help; for example, what types of problems would people take to ... social workers, ministers or priests, citizens advice, lawyers, marriage guidance counsellors, GPs ...?

20. Thinking about all these different professionals and the problems that we've mentioned, do you think there are certain problems, personal problems that people have that can get better by themselves or with help from these people without psychiatric help?

21. Do you think there are particular problems that require psychiatric help? Do you think there are any problems that can't be helped by psychiatry?

22. Psychiatrists don't always work in hospitals like this or in clinical settings, do you know what they do when they don't work in hospitals or the types of things they might give advice on? Do you know what they do?

23. (In your opinion) what would you say is the main job of the psychiatrists here?
(and also ask about) the nurses, occupational therapists, hospital social workers, clinical psychologists. Do you know what they do?

24. Who has been most helpful to you so far, either staff or patient? How about as far as practical things are concerned, like when meal times were and times of meetings and so on, did someone tell you about these? (If not answered already)

25. How much do you know about psychiatric treatment? If I mention various types of therapy to you, you may not have heard of them, not everybody has, can you tell me if you've heard of them, how much you know about them and when they would be used? For example, group therapy, drug therapy, psychotherapy, psychoanalysis, ECT, behaviour therapy ...

26. Have you ever seen any TV programmes, films/movies, documentaries, about psychiatric hospitals, psychiatric treatment or patients? (Ask for details; see if they thought they were accurate, reflecting what they found or expected and if it influenced their decision to come to hospital, or affected their attitudes about coming. Can also probe for this after next few questions at any point depending on answers. See if there were stereotypes portrayed.)

27. Have you ever read anything, books, magazine articles, newspaper articles, about psychiatric hospitals, psychiatric treatment or patients? (Ask for same as above.)

28. Have you ever talked about these sorts of things (or repeat - psychiatric hospitals, psychiatric treatment or patients) say even in general conversation? (Ask for same as above.)

29. (Depending on answers to above.) So from this did you build a picture of what it would be like here? Did all this influence your coming here in any way, or affect how you felt about coming?

30. Have any of your friends, or anyone you know, been in psychiatric hospitals or seen someone about nerves?
(and also ask about) relatives, members of your family, neighbours, people at work etc.

31. Can I mention various terms that people use, and people mean different things by them, but would you tell me what you think they mean? Say for example if someone was described as - having problems with nerves - what does that mean to you? How would they behave? (If this is not already answered.)
How about if a person is described as being slow?
What do you think mental illness is?
How about if a person is described as being simple? Mad/insane, sensitive, over emotional, highly strung, high/low spirits, neurotic?

32. (Carry on with same using diagnostic terms.)
Can I mention various diagnostic terms to you, again you may not have heard of them all, not everybody has, but can you tell me if you've heard of them, how much you know and what they would be like? For example - schizophrenic, manic depressive, obsessive compulsive, phobic, personality disorder, anorexia nervosa, drug dependent/ addict, alcoholic?

33. (In your opinion) why does a person become mentally ill, what would you say would cause it to happen? Are these the main factors? Is there anything else?

34. (In your opinion) do you think there's anything a person could do to prevent it happening in the first place, or that anyone else they know could do to prevent it? (And depending on earlier answers) Can they be cured?

35. (In your opinion) do you think it's possible to tell if a person is mentally ill, say if you didn't know them?

.....

36. Have you had any problems in the past that you went for help for or thought about going for help for? How serious did you think these problems were at the time? How about this time, did you feel your problems were more serious?

37. (Depending on answer to Question 9, repeat, again reviewing what they said earlier, find out about entire referral process.) Now this time can you tell me as much as possible about what happened. Did you feel any pressure was put on you? Did you discuss it with anyone?

38. Now that you're here, what type of treatment do you expect to get?

39. Is there anything else, any other/particular type of treatment that you'd like to get?

40. Is there anything about the hospital/ward/unit/this place, from your impressions so far, that you don't like, that you'd like to see different?

41. How long do you expect to be here? (Find out why they think this, if anyone told them a particular time etc.)

42. How do you feel about being treated in this particular hospital/ unit?

43. Is there anywhere else you would prefer to be treated, or by anyone else?

44. What do you think the psychiatrist will do now to help you?

45. What do you think he'll want you to do to get better?

46. Do you see yourself as different in any way from people who're not in hospital? How do you see yourself? Do you see yourself as ill?

47. Is there anything (else) about yourself that you're not happy with - that you'd maybe like to change in some way?

48. Before you came here, did you feel that you were getting any support/help with your problems?

49. How about when you leave, will you tell people you've been here?

50. (Continue from above) How do you think people will react, do you think they might act or feel badly towards you because you've been here?

51. Do you think people generally feel this way (or if applicable) - generally feel or act badly towards people because they've been here? For example do you think the other people on the ward will have problems when they leave because they've been in here?

52. When you leave here, how do you think people will go about helping you, supporting you, with your problems.

.....

53. Can I just ask you a few questions now about how many people you know and see regularly.
(Ask for details of number of people in same dwelling, family members, relatives, close friends, acquaintances, neighbours, colleagues; how often they see them and on what basis.)

APPENDIX II

Alternatives to Interview Schedule for Newfoundland

3. Can you tell me what your job is?

6. How far did you go in school? Did you get your Grade 11?

7. Where do you live? Where do you belong? Is that your own house or someone else's?

9. and elsewhere; substitute 'family doctor' or 'your doctor' for 'your GP'.

15. and elsewhere; substitute 'sick' for 'ill'.

19. Include 'welfare', 'Legal Aid'. Omit 'Citizen's Advice, 'Marriage Guidance'. Include 'teachers' and 'public health nurses'.

26. ... or films or talks in the community, say like those given by the public health nurse ... soap operas ... open line programmes on the radio ...

27. ... or pamphlets on emotional problems, say for example the kind given out by the public health nurse ...

31. (Different terms in common usage, add 'foolish', 'retarded', 'down', 'silly', 'stun'.

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