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The Ascription of Mental Illness: Inside Societal Reaction

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The Ascription of Mental Illness: Inside Societal Reaction

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

Abstract

Mental illness is examined as a classification of deviance and as a social process. The labeling perspective provides preliminary concepts and problems for research. The goal of research is the examination of the process of ascribing the label "mental illness" to individuals and their behavior by significant others prior to their contact with official and organizational agents of treatment and control.

An exploratory interview research design within the Fan district of Richmond, Virginia was executed. Fifty residents were interviewed. Preliminary data suggest that the primarily white, female, well-educated, professional sample was unwilling to stereotype the mentally ill, and revealed typifications of mental illness which differed significantly from those in previous research. Mental illness was ascribed primarily to individuals who were known well and who were observed as acting abnormally for their personal biographical situation and unable to function over a continued period of time.

Introduction

The phenomenon of mental illness ("insanity," "madness," "craziness," "nervous breakdown," "mental disorder," etc.) is singular neither in its dimensionality nor in its pursuit by a significant cross-section of scholarship. Its manifestations are treated as somatic disease, sociocultural adjustment, experiential product and countless other conceptualizations. It is the subject of investigation in medicine and psychiatry, psychology, anthropology, sociology, social work, philosophy, literature and other disciplines. Whatever else it may be, mental illness is, and occurs within, a social process. It is a classification of deviance whereby certain experiences, behaviors and individuals exhibiting those behaviors come to be known, accepted and treated as being characteristically mentally ill. Such individuals are differentiated from the non-deviant population with readily discernable consequences for both groups. Therefore the process whereby this differentiation occurs warrants investigation.

The bulk of sociological research into mental illness falls into the following categories:

1. classical epidemiological research on rates of incidence and prevalence utilizing a disease model of mental illness;

2. etiological research upon institutionalized mental patients utilizing socialization and environments of social relationships within a learned social deviance model of mental illness;

3. societal reaction (labeling) etiological research stressing the role of lay and professional members of the community in the "construction" of mental patients;

4. social psychological (phenomenological and symbolic interactionist) research into the effects of mental illness on individual selves, self-concepts, identities, etc.

This work is not concerned with the etiology of the behavior within the individual which comes to be regarded as deviant. It is granted that such behavior arises within a variety of physiological, psychological, social and cultural circumstances. The object for investigation is rather: the determination of definitions, typifications and stereotypes of mental illness by lay members of the community, and the examination of the process of ascribing the label "mental illness" to individuals and their behavior by significant others prior to their contact with official and organizational agents of treatment and control.

Preliminary research with the above goals in mind can serve to develop categories for the definition of mental illness and devise and refine both an interview schedule and research design for further research. The labeling perspective provides a conceptual scheme for these problems. It has been developed as an alternative to the medical model of mental illness, which states that deviant behaviors are recognizable, symptomatic manifestations of specific, underlying pathologies within the individual.

Labeling (Societal Reaction to Deviance)

Frank Tannenbaum (1938:19-20) was instrumental in the shift of emphasis away from deviance as a quality inherent within the act itself, and the sources of deviation as located within the structure of a society, toward the roles played by others in its invocation and application, and the consequences of both the moral order and social control:

> The process of making the criminal is a process of tagging, defining, identifying, segregating, describing, emphasizing, making conscious and self-conscious; it becomes a way of stimulating, suggesting, emphasizing and evoking the very traits that are complained of. The emphasis is upon the conduct that is disapproved of.

He was followed more systematically by Edwin Lemert (1951: 387-88) who asked the question, what is it about human beings' behavior which leads the community to reject them, segregate them and otherwise treat them as irresponsibles, i.e., as insane, and what are the functions of such rejections and concomitant societal definitions in the dynamics of mental deviation itself. Lemert and a host of others (Mechanic, 1962; Becker, 1963, 1964; Kitsuse, 1964; Erikson, 1964; Scheff, 1964, 1966, 1967; see Gove, 1975b:3-19) laid the foundation of labeling's conceptual scheme which was to conceive of deviance as the application by others of rules and sanctions to an offender rather than a quality of the act the person commits, and the deviant as one to whom the label (deviance) has successfully been applied (Becker, 1963:9). An individual exhibits "pathological" behaviors (primary deviation) for whatever reason, becomes labeled deviant, accepts the role

accorded by others for deviants, and subsequently performs in that role of deviant (secondary deviation):

> Primary deviation is assumed to arise in a wide variety of social, cultural and psychological contexts. The deviations remain primary deviations or symptomatic and situational as long as they are rationalized or otherwise dealt with as functions of a socially acceptable role.
>
> When a person begins to employ his deviant behavior or a role based upon it as a means of defense, attack or adjustment to the overt and covert problems created by the consequent societal reaction to him, his deviation is secondary (Lemert, 1951:75-76).

The social psychological perspective of symbolic interactionism (Mead, 1934; Shibutani, 1961; Rose, 1962; Blumer, 1969; Stone and Farberman, 1970; Lauer & Handel, 1977) provides the basic concepts (such as societal reaction, stigma, degradation, mortification of self, typification, stereotype, moral and deviant careers, identity crisis, role encapsulation) and propositional statements for labeling theorists and researchers. Labeling as a dependent variable seeks to explain why certain individuals come to be labeled deviant and others do not (Gove, 1975b:9). Labeling as an independent variable examines and reveals the transformation of an individual's self, self-concept, identity, role and behavior (Gove, 1975b:12). Research has sought to explain secondary deviance as a result of primary deviance and labeling in a deviant "career," by focusing upon individuals who have necessarily reached official and organizational agents of treatment and control, such as arrestees, convicted criminals, institutionalized mental patients and drug rehabilitatees. The accent has been upon the arbitrariness of official action, stereotyped decision-making in bureaucratic contexts, bias in the administration of law, and the general preemptive nature of society's control over deviants (Lemert, 1972:16).

Deviance is operationally defined for the purposes of this research according to Schur (1971:24):

> Human behavior is defined as deviant to the extent that it comes to be viewed as involving a personally discreditable departure from a group's normative expectations and it elicits interpersonal or collective reactions that serve to isolate, treat, correct or punish individuals engaged in such behavior.

The reaction of others to deviant behavior is situationally and personally dependent. According to Kitsuse (1964:101) the socially significant differentiation of deviants from the non-deviant population is contingent upon the circumstances of situation, place, social and personal biography, and the bureaucratically organized activities of agents of social control. More specifically, Scheff (1966:96-97) states that the severity of the societal reaction is a function of:

1. the degree, amount and visibility of the rule breaking;
2. the power of the rule-breaker and the social distance between him and the agents of social control;
3. the tolerance level of the community and the availability in the culture of the community of alternative nondeviant roles.

While these are elements primarily external to the actor and the reactor, one can now attempt to look within the reacting individual to examine the social psychological processes which contribute to the determination of the reaction within a given interaction episode:

> ... any pattern of human reaction to others, individual or collective, is a mixture or product of prior symbolically transmitted knowledge, past knowledge acquired from experience with the objective world, and

newly invented meanings derived from immediate experience with the social and physical worlds (Lemert, 1974:461). See Figure 1.

The societal reaction process within the individual who is reacting to an actor and his/her behavior can be described as follows (Hawkins & Tiedeman, 1975:64-65):

1. Observation. The act is monitored in some way so that its occurrence is known.

2. Recognition. The act is seen as a rule violation - i.e., a violation of rules-in-use. Implied here is a recognition of what the rules are.

3. Imputed Cause. The act is categorized as accidental, not really intended or intentional by the observer.

4. Motive. The question of the motive or intention of the actor is considered in evaluation of behavior (Blum & McHugh, 1971). Motives are related stereotypically to roles. Accounts may be offered by the actor as evidence of motive (Scott & Lyman, 1968).

5. Potential Reactions. The observer (witness to rule violation) rehearses possible reactions to act and actor based upon situational factors, normalization and denial attempts, typifications of role suggested by motive imputation, rules-in-use and other factors.

6. Reaction is Chosen. Reaction which is chosen among the alternatives possible is determined in part by the background and training of the reactor - especially if he/she is a social control agent (Scheff, 1967), organizational categories available for use (Garfinkel, 1967; Douglas, 1971), existing precedents which are invoked by analogous reasoning (Douglas, 1970: Ch.1), societal expectations as to appropriate sanctions and prescribed reactors (Gibbs, 1966b) and other factors (Clark & Gibbs, 1965).

7. Impact of Reactions. What is the potential influence of reactions on the actor's

> future behavior, on perceptions of opportunities to conform or deviate, and on personal identity?

It is important to note here the difference between rule-breaking and deviance (Becker, 1963; Scheff, 1966). A large amount of rule-breaking occurs which never becomes deviant. Rule-breaking can occur without the awareness of others, or it may occur with others knowing about it but denying its nature and severity or dismissing it as being situationally idiosyncratic. To become deviant, behavior must be so recognized (perception), attributed to an individual (labeling), and utilized as a source of appropriate treatment (action) (Kitsuse, 1964; Edgerton, 1969).

Still it must be heeded that deviance outcomes flow from the interaction between attributes of persons and their actions, and the societal reaction (Lemert, 1972:21). Implicit in the statements of labeling theorists is the contention that deviance, and this case specifically mental illness, is to some extent an ascribed status, "reflecting not only the deviating individual's activities but the responses of other people as well" (Schur, 1971:12). Sociologically, then, a critical variable is the social audience since it is the audience which eventually decides whether or not any given action or actions will become a visible case of deviation (Erikson, 1962:308).

Societal reaction research has largely concerned itself with focusing upon the extent to which an individual's acquisition of the deviant label is independent of his/her behavior or experiential condition (and therefore by implication, dependent upon the defining and application of sanctions by

others) (Scheff, 1974, 1975a, 1975b, 1976; Gove, 1974, 1975a, 1975b, 1976; Krohn & Akers, 1977; Glassner & Corzine, 1977; Theis, 1977).

Labeling Mental Illness - Stereotypes and Typifications

The application of the labeling perspective to mental illness has been most explicitly developed by Scheff (1966, 1967, 1975) as an alternative to the medical model approach. That symptoms of mental illness are linked to culture leads Scheff to conceive of mental illness as the breaking of rules and the violation of norms which are the residue of violations after all other deviance categories have been exhausted. The fact that the behavior constituting such residual rule violations may be an expression of underlying physiological and psychological processes is not questioned by Scheff (1975:7). But as the medical model's scientific verifications yet elude its adherents, he is wont to point out the contingencies external to the individual and his/her behavior which determine the labeling of mental illness. Of the nine propositions which serve as the basis of Scheff's theoretical approach (1966:40-93), two are of central concern for this research:

> Stereotyped imagery of mental disorder is learned in early childhood;
>
> The stereotypes of insanity are continually reaffirmed, inadvertently, in ordinary social interaction.

Such stereotypes serve as the basis for societal reactors' decision-making (labeling or denial) when they are confronted with an actor and his/her behavior. Because each individual cannot know each other individual personally throughout one's lifetime, methods of cognition, of "knowing about people," are devised in order to confront the phenomena which are unique in their occurrence in time and space and to make these phenomena intelligible and explicable (McKinney, 1970:245):

> Public decisions must be made about, and stances taken toward, people known about but not known. The roles of others must be taken in the absence of face-to-face knowing. As a result, typifications and stereotypes are used as substitutes for the kind of understanding obtained in face-to-face access to the minds of others (Lofland, 1971:2).

A stereotype refers to those folk beliefs concerning the attributes characterizing a social category on which there is substantial agreement (Mackie, 1973:435). It is capable of operationalization as "a collection of trait-names upon which a large percentage of people agree as appropriate for describing some class of individuals" (Katz & Braly in Mackie, 1973). Stereotyping is often confused in its use and application with the general process of typification:

> All typification consists in the pragmatic reduction and equalization of attributes relevant to the particular purpose at hand for which the type has been formed, and involves disregarding those individual differences of the typified objects that are not relevant to such purpose (McKinney, 1970: 247).

Whereas typifications are employed by individuals in apprehending the world, stereotypes are typifications which are agreed upon by a given group of individuals.

Whether stereotypes do in fact exist in varied form and content, or are artificial constructs of social scientists and journalists imposed upon collectivities, is an important yet unresolved question. It may be more accurate and functional to utilize the concept of typification. That is, individuals may yield similar typifications but may not necessarily reflect a common stereotype, which suggests a uniformity of thought.

Typifications are descriptions drawn from a common stock of knowledge which serve as short-hand notations for various phenomena (Hawkins & Tiedeman, 1975:82). They are simplified, standardized categories or labels used to place other people or things:

> The reality of everyday life contains typificatory schemes in terms of which others are apprehended and "dealt with" in face-to-face encounters (Berger & Luckmann, 1966:30-31).

Typification is operationalized to be the total number of trait-names which an individual uses to describe some class of individuals or objects. The typifications produced in everyday interactions allow the summarization of one's constantly unique subjective experiences into objective (i.e., externalizable) descriptions, which are less bounded by time and space (Hawkins & Tiedeman, 1975:82). When an individual observes others, he/she is interested in whether or not others's behavior is representative of some referent group, category or behavior as an instance of a class of behaviors (McHugh, 1968).

Thus typification, "perceiving the world and structuring it by means of categorical types" (McKinney, 1970:243), is a characteristic of all human perception (McKinney, 1970:253; Hawkins & Tiedeman, 1975:82). Schutz (1962:7-19), in summing up Husserl's analysis of the typicality of the world of daily life, describes the function of typifications when an individual confronts an object:

> ... the result of the selecting activity of our mind is to determine which particular characteristics of such an object are individual and which are typical ones.

The more anonymous the typifying construct, and the more

distant the relationship of individuals involved, the less accurately will the typification represent the personality and behavior pattern of the individual being perceived (Schutz, 1962:18). If actual experience confirms one's typification, at the same time it becomes enlarged and divided into subtypes in order to accommodate the individual characteristics of the object at hand.

Typifications and stereotypes may or may not be incomplete and inaccurate devices yielding "distorted appraisals and reactions" to the world of objects (Simmons, 1969:26). The evidence for both sides remains incomplete and contradictory (Mackie, 1973). Yet it would appear that interpreting the world in terms of typified and stereotyped categories is a necessary human process (Simmons, 1969:26).

The degree and kind of typifying and stereotyping vary among individuals and groups, but their presence appears to be universal. Schur (1971:41) provides a dual significance for these devices:

> 1. they reflect the needs of participants in complex interactions to order their expectations so that they can predict the actions of others, at least to the extent sufficient for coherent organization of their own behavior;
>
> 2. when we think of the selective perception frequently involved in this process, we recognize that the potential for reactions based upon inaccurate assessments is substantial.

Stereotypes serve the purpose of acting as societal boundary maintenance mechanisms. When one is confronted with an interaction episode involving a "deviating" actor, they are called upon to aid the societal reaction process.

> In a crisis, when the deviance of an individual becomes a public issue, the traditional stereotype of insanity becomes the guiding imagery for action, both for those reacting to the deviant and at times, for the deviant himself (Scheff, 1966:82).

The social process of labeling individuals and their behavior as being mentally ill begins with persistent interpersonal difficulties between the actor and his/her family, friends, work associates and superiors, neighbors or others within the community (Mechanic, 1962; Lemert, 1973:108). Research by Scheff (1964:413) led him to report the following:

> This finding points to the importance of lay definitions of mental illness in the community, since the "diagnosis" of mental illness by laymen in the community initiates the official societal reaction, and to the necessity of analyzing the social processes connected with the recognition and reaction to the deviant behavior that is called mental illness in our society.

The so-called "lay" members of society not only precede the official and organizational agents of treatment and control temporally in their interactions with "mentally ill" individuals, but also in the defining of which behaviors constitute mental illness:

> Mental illness is possible because members, in very small and ordinary ways, treat certain behavior as "mentally ill" and collaboratively develop systematic ways of recognizing, categorizing and acting upon such behavior (Blum, 1970:35-43).
>
> ... any type of insanity is constituted as such only in the context of practical interactions and their attendant ordinary judgmental processes. We make ascriptions, imputations and appraisals of members, their situations and the "fit" between the two (Coulter, 1973:43-47).
>
> And it is how members of the culture use

> the categorical typifications in their everyday language to create and describe that activity - of being mentally ill, which needs to be sociologically examined (Imershein & Simons, 1976:561).

Early in the history of the labeling perspective, Kitsuse (1964:88) laid out two important questions for researchers: what are the behaviors which are defined by members of the group, community or society as deviant, and how do those definitions organize and activate the societal reactions by which persons come to be differentiated and treated as deviants? Whereas research has been extensive within the labeling perspective, it has not always directly addressed these questions.

Mental Illness and the Public - Review of Research

Research in this area has utilized two methods primarily. The use of recall interviews with patients, former patients and their families (Yarrow, et al., 1955; Sampson, et al., 1962) has sought to reconstruct the events leading to hospitalization. More frequently and systematically, written and visual vignettes or case descriptions of six psychiatric categories (paranoid, simple schizophrenic, alcoholic, anxiety neurotic, disturbed child, compulsive-phobic) of individuals have been utilized in order to elicit imagined judgments and reactions (Woodward, 1951; Star, 1955; Cumming & Cumming, 1957; Spiro, et al., 1973; Karno & Edgerton, 1974; D'Arcy & Brockman, 1976). The early studies were designed as programs in the education (attitude and belief change) of the public in mental health and mental illness. More specifically, their intention was the public's acceptance of the psychiatric classification and categories of mental illness. Also an attempt was made for the public to accept psychiatrists as the agents of treatment rather than lay members of the community or other professionals. In short, these studies, funded by such organizations as NIMH and NAMH, were designed to bring about the public's acceptance of the psychiatric ideology and the medical model of mental illness:

> ... when we talk about the long-run aim of mental health education, we are talking about bringing about a veritable revolution in people's ideas about some very fundamental questions (Star, 1955).
>
> Our study was designed to investigate to what extent and in what directions attitudes

> toward mental illness are changed by an intensive educational program (Cumming & Cumming, 1957).
>
> In the meantime the local psychiatrists and social workers were fully aware that the attitudes toward the mentally ill which prevailed among the lay population were making it extremely difficult to rehabilitate the patients from large hospitals (Cumming & Cumming, 1957).

Not only does this type of research present the problem of extrapolated responses through the use of vignettes and fixed-choice questions, but the inherent psychiatric bias of intent may have directed the results of the research more than the researchers were aware of. Lemert (1951:387) addressed this very problem:

> We have in mind here chiefly the reliance of sociologists upon psychiatric classifications for descriptions of the elements of the sociopathic phenomena they seek to study.
>
> Research formulations resting upon concepts such as these can only by much indirection and inference pose, and seek answers to, questions of genuine sociological concern about mental disorders.

The possibility of biasing the results of these research endeavors toward those in favor of psychiatric interpretation and away from commonsense or folk knowledge of mental illness certainly exists. As all subsequent studies have used the schedules and techniques of their predecessors, they must stand upon the strengths and weaknesses of the early works.

Research has also been plentiful in the investigation of the official and organizational segments of the mental illness process (see Scheff, 1974; Gove, 1975b), but sparse in the initial and less formalized phases. What is needed is the

examination of the process of ascribing the label "mental illness" to individuals and their behavior by significant others prior to their contact with the official and organizational agents of treatment and control. What is also needed is more recent research into the typifications and stereotypes of mental illness held by various lay members of the community:

> That which needs to be done is to search for attributes which are common to all mental disorders and to discover the continuities between "normal" and psychotic behavior.
>
> ... we may then construct serialized classifications in which the basis for inclusion of cases in various categories is made explicit (Lemert, 1951:389).

Star (1955) conducted 3500 interviews and found that "about half" of the American public equated the mentally ill with being "insane," "crazy," "nuts," or "out of their minds," and attributed to them such characteristics as unpredictability, impulsiveness, loss of control, extreme irrationality and legal incompetence, and such symptoms as violent behavior, incomprehensible talk, delusions or hallucinations. Three interrelated conditions were found to be generally regarded by the public as being necessary for determining behavior as proof of mental illness:

1. a breakdown of intellect, an almost complete loss of cognitive functioning, or a loss of reason;

2. a serious loss of control, usually to the point of dangerous violence against others, where one is not responsible for one's acts;

3. behavior should be inappropriate, i.e.,

> neither reasonable nor expected under the particular circumstances in which the individual finds him/herself.

Woodward (1951), Crawford, et al. (1960) and Nunnally (1961) found that the public believed the mentally ill to be highly unpredicatable and anxious.

Marolla (1974) surveyed a sample of University of Rhode Island undergraduate students with an open-ended instrument, and elicited the following most frequently cited characteristics of mental illness: emotional instability, paranoia, unusual behavior, anxiety, irrationality, inability to differentiate reality from fantasy, withdrawal, unpredictable behavior, moodiness, depression and nervous mannerisms..

Reactions of the public to mentally ill individuals were generally found to be fearful and threatened. "Emotionally, it represents to people loss of what they consider to be the distinctively human qualities of rationality and free will, and there is a kind of horror in dehumanization" (Star, 1955).

Stereotypes have been found to have become less negatively stigmatized over time and to have changed in content from folk beliefs to a more medically oriented and informed content:

> The old ideas that the mentally ill were bad and dangerous, and hence to be punished (on the one hand) or were ludicrous and silly, and hence to be laughed at (on the other) seem to be to a considerable extent superseded by the feeling that mental illness is a sickness that should evoke sympathetic understanding and that requires some form of professional treatment (Woodward, 1951:484).

That such findings were ubiquitous may indeed be more a function of the nature and kind of questions being asked (fixed-choice, oriented toward medical and psychiatric responses),

than of any change in the existential attitudes and common-sense interpretations of the public. That stereotypes have been found to be present in most research results must be considered in light of the fact that research of this kind carries the potential weakness of extrapolating something which may exist in a different form or may not exist at all in the everyday life of the public.

Research has demonstrated that urban populations are less prone to stereotype the mentally ill than rural populations (Crawford et al., 1960), that younger populations are less rigid in their stereotyping than older populations (Woodward, 1951; Cumming & Cumming, 1957), and that educated populations are less rigid in their stereotyping than lesser educated groups but nonetheless maintain what is called a secondary stereotype which is derived from medical and psychiatric terminology and explanations (Simmons, 1969; Marolla, 1974). Sex, race, marital status and experience with labeled individuals have been found to affect attitudes; however, the evidence is insufficient and contradictory (Crocetti, et al., 1974). Simmons and Cumming & Cumming determined that individuals who scored higher on liberalism and social distance scales were less prone to stereotype than those with lower scores, attached less of a stigma to mental illness, and exhibited more favorable reactions and responses toward mentally ill individuals.

Research Problem

There exists then a need to conduct research which will yield information on the processes of typifying and stereotyping mental illness in terms of the commonsense categories which lay members of society employ in their everyday interactions. Research is also needed which will examine the interaction episodes wherein an actor is first undergoing behavioral difficulties sufficiently severe to warrant the attention of his/her significant others. The questions which emerge for research are the following:

1. how is the phenomenon of mental illness conceived of and defined in terms of commonsense knowledge among lay members of the community;

2. what typifications and stereotypes, if any, of mental illness and its behaviors are held by community members;

3. what events take place within specific interaction episodes between actors and their significant others where the ascription of mental illness occurs;

4. what, if any, effect does direct experience with individuals labeled mentally ill have upon one's typifications and stereotypes of mental illness.

Grounded Theory and Empirical Investigation

At this point it is necessary to address the nature of the relationship between theory and research. Given that a number of research questions have been raised, and that one seeks to provide information toward the answering of such questions, what type of research should be conducted, and the relation of the research and data yielded thereby to sociological theory are critical areas of concern. Blumer (1969: 1-60) states that an empirical science has to respect the nature of the empirical world that is its object of study, and that as the object of sociological investigation is human group life and conduct, one needs to develop a methodological perspective that will be congruent with the world of everyday human experience. By acquiring first-hand experience and acquaintance with the object of research, the social scientist can reformulate his/her pre-established images. The constructs and concepts of the social scientist must reflect the meaning - and relevance-structures of the human beings who are the object of investigation:

> When science begins to classify and analyze its data, it is taking a definite and formal step away from reality at the level of folk classifications and existential typologies.
>
> ... the sociologist is presented a preconceived and prestructured social order by actors constructing and utilizing their own typifications.
>
> ... the social scientist cannot settle for these existential types; he must, in turn, treat them as data in the construction of types which in effect typify the typifications (McKinney, 1970).

A methodological orientation which seeks to derive concepts, their relationships, and theoretical schemes from the world of human social life is proposed by Blumer:

1. direct examination by confronting the empirical world available for observation and analysis;
2. raising abstract problems with regard to that world;
3. gathering necessary data through careful, disciplined observation of that world;
4. unearthing relations between categories of such data;
5. formulating propositions with regard to such relations;
6. weaving such propositions into a theoretical scheme;
7. testing the problems, data, relations, propositions and theory by renewed examination of the empirical world.

Lofland (1971) calls for a commitment to representing the participants in their own terms with the scientific goal of explicit and articulate abstraction and generalization; in short, analysis. By learning the participants own analytic ordering of the world (categories for rendering explicable and coherent the flux of raw reality) the analyst is then able to provide a more articulate and clear portrayal of that order.

Glaser & Strauss (1967) argue similarly for the grounding of theory in social research by generating it from data. One of their methods for grounding theory that is applicable to the research problem here is that of theoretical sampling. It is a process of data collection for generating theory whereby the analyst jointly collects, codes and analyzes data, and decides what data to collect next, where to find them, etc. in

order to develop a theory as it emerges. One should initially enter the empirical world with only a general sociological perspective and only a general subject or problem area. The concepts and categories are commonsense and vague at first, but the researcher should be sufficiently theoretically sensitive, in order to be able to conceptualize and formulate a theory as it emerges from the data. At a later stage of the research process, comparative analysis can replace theoretical sampling for a more large-scale examination of the empirical world and the testing of the initial concepts, propositions and theoretical scheme. The emphasis is upon the research process whereby theory is constantly reworked and reformulated through grounding in data over and over again (Glaser & Strauss, 1967).

Concepts employed should be "sensitizing" (give a general sense of reference and guidance in approaching empirical instances and suggest directions along which to look), rather than "definitive" (refers to what is common to a class of objects; clear definition in terms of attributes or fixed bench marks) in order to work with and through the distinctive or unique nature of the empirical instances (Blumer, 1969). This enables the researcher to reduce the gap between scientific concepts of an ideal typical nature and the commonsense concepts employed by actors, as well as that between the empirical instances and objective concepts and an objectively verifiable theory of subjective meaning-structures (Schutz, 1954).

Research Methodology

As it is not possible to introduce the researcher into the interaction settings wherin actors are exhibiting behaviors and their significant others are reacting to these behaviors in the initial stages of the labeling process, any feasible research strategy will be necessarily incomplete, given the goals of this research. Nonetheless, exploratory research can begin the process of the grounding of theory through theoretical sampling, which is aimed at the research questions at hand, and which attempts to get closer to the desired interactions.

By defining an urban community population, and executing an interview research design using a systematic random sample thereof, one may begin to generate categories of responses to the research questions and uncover relationships between them. Randomization of the sampling allows for maximum theoretical sampling. That is, the researcher seeks to sample individuals from as many population groups as possible, in order to saturate all possible categories with data from all possible population groups' representatives, within the universe. The unit of analysis, for the present, is the individual, who becomes a source of input for data concerning the definition of, and direct experience with, mental illness.

The Fan district of Richmond, Virginia was selected because it is an urban residential community with definable geographic boundaries and possesses an identity which is recognized both by its own residents and the larger urban population. The concept "community" comprises both ecological

and normative dimensions (Hunter, 1974). The latter includes social interaction, social structure, shared collective representations and moral sentiments. By examining the classification and application of deviance, it is possible to reveal the general process by which normative standards arise and are enforced.

The Fan district provides a heterogeneous source of lay members of a community who in their everyday interactions may take part in the labeling process, and who become accessible to investigation without having to conduct research through the more formally organized aspects of the mental health care delivery system. One can then attempt to get one step closer to the desired interactions than previous research attempts.

The Fan district lies adjacent to the central business district of Richmond with a heterogeneous population of approximately 14,661 (1970 census block statistics). Drawing on census data, it is possible to obtain a picture of the population, if a somewhat inaccurate one, since many changes may have occurred in eight years. Of the total population, 45% are males and 55% are females. The community includes 1.5% blacks, while 35% of the total population are single, 35% married, 8% divorced and 22% either separated or widowed. The median number of school years completed is 12.4 and 57% of the population have completed high school. Approximately one quarter (22%) of the residents are employed in professional or technical type occupations. Nearly half (45%) of the occupants of housing units in the Fan district have resided there for a period of two years or less. The community comprises 110 blocks, using a central of three possible boundary

delineations, and 6,136 occupied residential units (4,773 renter-occupied, 77.8%, and 6,136 owner-occupied, 22.2%). What has happened to the Fan since 1970 is not known.

In order to gain access to as many of the various population groups in the community as possible, an attempt was made to select a random sample of dwelling unit residents by contacting 500 dwellings (every 12th dwelling). This was accomplished by assigning each dwelling unit per block a number, starting at the southwest corner of each block and selecting a random number between 1 and 12 to determine which dwelling unit was to be contacted first, and then proceeding to every 12th dwelling unit, repeating the procedure for each block.

Once dwelling units were selected, a letter describing the research endeavor was mailed with a postage-paid return post card which provided for the respondent's name, address, telephone number, willingness to be interviewed and preferred time of day when they could be contacted by telephone in order to establish an interview date and time (Appendix 1,2). A minimum goal of 50 completed interviews was set.

It is recognized that any sampling procedure carries with it potential non-response biases, but that which was chosen for this research is advantageous in that it lends an element of legitimacy to the interviewer and to the research itself. Even more improtantly it respects the privacy of the human subjects who are the object of investigation.

An interview schedule, which makes use of sections of earlier research schedules, such as Star and Marolla, but

which seeks to avoid the preoccupation with psychiatric and medically-oriented questions and fixed-choice responses, was devised (Appendix 3). The instrument sought to elicit a commonsense understanding of mental illness, expected behavior, speech, communications and appearance of mentally ill individuals, necessary conditions for mental illness, and the description of direct experience with individuals labeled mentally ill, including the actual behavior of those observed. Also included were expected reactions to mentally ill persons and the actual reactions to those with whom interviewees had come in contact.

Using the steps of the societal reaction process described by Scheff, Kitsuse and Hawkins & Tiedeman previously, the researcher analyzed the data in terms of typifications and stereotypes of mental illness, how behavior was observed and reacted to by significant others, and how the determination of mental illness as a label applying to the behavior and the actor was made. Written informed consent was obtained from each respondent prior to interviewing (Appendix 4).

Whereas a longitudinal study comparing responses before and after direct experience with labeled individuals is beyond the scope of this research, it was possible to artificially create the two groups, while recognizing that the responses concerning recalled events are subject to retrospective interpretation. One seeks to sample all possible groups, and while direct comparison is not possible, it is conceivable that the two groups' responses may differ significantly.

Additionally, a number of demographic variables (sex,

race, age, marital status, education, occupation, type of residence and length of residence) were included in order to note any possible differences or effect upon the individuals' responses. Tape recording and note-taking techniques were utilized for data gathering during the interviews.

The constant comparative method of qualitative analysis was used jointly with the theoretical sampling methodology (Glaser & Strauss, 1967:101-115). Its goal is generating and plausibly suggesting as many categories, properties thereof, and hypotheses about the research questions as possible. It is a four-stage process:

1 - comparing incidents applicable to each category;

2 - integrating categories and their properties;

3 - delimiting the theory;

4 - writing the theory.

Categories were generated along the following lines, as one method chosen from a number of available options for qualitative analysis. Responses to the 22 questions asked were initially grouped according to perceived similarity of intended meaning or function. This served as a primary collapsing of the numerous responses. Secondly, these response groups were distributed under a number of chosen categories or types of responses, which serve to in effect describe the descriptions of the interviewees. The categories were derived from the response items themselves and comprise the following: synonym, medical/psychiatric terminology, behavioral description, psychological description, verifiable description,

uncharacterized description, general description, sympathetic/supportive reaction, inquisitive reaction, non-involvement reaction, general reaction, and negative reaction. Although these categories are somewhat artificially imposed upon the data, it is felt that they are more derived than imposed, and useful as descriptive guides which allow large data to be reduced to categories which may then be fit into relational statements. They are not intended to be aggregate units in the traditional sense, and are subject to reformulation at any time.

The creation and exhaustion of categories, and relational statements which are made between categories are the end products sought by this research. The end result of this type of analysis need not be arriving at the level of theory generation.

One goal of the research is the revelation and examination of existential attitudes (those which are operative in and arise out of an actual situation). However the very act of research itself causes the final product to be, rather, extrapolated attitudes (those which are projected into an imaginary situation) to a large extent (Lauer & Handel, 1977: 49; Hawkins & Tiedeman, 1975; McKinney, 1970). Additionally, the recall of past events subjects them to potential retrospective interpretation. As long as the research takes such dynamics of the research act into account in the analysis and report of the data, the end results can yet be significant.

Analysis and Findings

Responses have been organized and analyzed under a number of topic headings. The 13 topic headings are: definition of mental illness, expected behavior of a mentally ill individual, expected speech/communication of mentally ill individual, expected look/appearance of mentally ill individual, necessary conditions for mental illness, expected reaction to mentally ill individual, experience with and relationship to those labeled mentally ill, circumstances of contact with those experiencing mental illness, actual behavior of mentally ill individuals, actual reactions to mentally ill individuals, help obtained for individuals experiencing mental illness, outcome of individuals experiencing mental illness, and demographic characteristics of the sample. The frequencies of responses to these items by the sample are provided in Table 14.

Demographic Characteristics of the Sample

Of the 500 residents contacted, 76 consented to be interviewed and 50 were interviewed (Table 13). These comprised 14 males and 36 females, 49 of which were caucasian and 1 was black. The mean age of interviewees was 31 years. Thirty-four interviewees were single, 11 married and 5 divorced. Of the total sample, all but four had had at least some college education, with 16 being college graduates and another 16 having either some graduate training or graduate degrees. Occupations varied from students (10) to a range of what can be seen as primarily professional types (Table 13). The average length of residence was 6.6 years, while 15 residents

were homeowners and 35 rented apartments.

Despite the inaccuracies of the reliance on 1970 census data, it can be safely said that the sample does not represent the overall Fan district population, since it is one that is primarily female (72%), white (98%), young (66% bet.20-29 yrs.), single (68%), well-educated (all but 8% with some or more college) and employed in professional type occupations (or students). The percentage of blacks however is similar. Length of residence appears to be similar with the 1970 data, with 44% of the sample having resided in the district for 2 years or less. Also renters comprised 70% of the sample, which is comparable with the 78% renter-occupied housing units in the Fan district.

While a systematic random sample of the district was selected, the resulting sample obtained was not a random one. Both the non-representative population characteristics of the sample and the 67% no-response rate serve to indicate this fact. (Table 13).

Definition of Mental Illness

Mental illness was described most frequently as being an inability to cope with everyday life or one's problems, emotions or reality (56%), and as a difficulty or inability to function (28%) (Table 1). Nearly a third (30%) of the sample refused to characterize mental illness beyond saying that it entailed many different things, depending upon the person and type of mental illness. Relatively few interviewees (22%) used terms of similar or synonymous description for mental illness such as crazy, insane or losing one's mind. This is consider-

ably less than those in Star's findings, the major research which gives comparable definitional descriptions for mental illness. Typifications were given which described the behavior or psychological state of a mentally ill individual, such as loss of touch with reality or emotional disturbance, but only 14% used medical or psychiatric terminology. Considering the well-educated sample, it would be expected that this figure would be larger, given the work of Simmons and Marolla.

While similar typifications were yielded by interviewees, no significant stereotypes emerged in terms of a fixed image of the mentally ill which a large percentage of the sample agreed upon. The only stereotype found was that interviewees refused to stereotype beyond a general description of mental illness as a dysfunction.

Expected Behavior of Mentally Ill Individual

The majority of interviewees (56%) did not expect any particular behavior of the mentally ill, but rather that it could be many different ways or a range of behavior depending again upon the person and the type and severity of the mental illness. Another 16% felt that one would act normal or no different from anyone else. Typifications of expectation were most frequently descriptions of one's psychological state such as unaware of one's actions or surroundings or inability to control one's emotions. Behavior expected included violence or dangerousness to self or others (24%) and an inability to function (Table 2).

The expectations of behavior for the mentally ill do

compare favorably with Star, Woodward and Marolla findings, however a wider range of typifications were yielded in this sample, and again no clearly overwhelming stereotypes emerge but the refusal to stereotype. Only 24% felt that the behavior would be abnormal, peculiar or bizarre in general.

Expected Speech/Communication of Mentally Ill Individual

Over 1/4 of the sample felt that either there would be no difference or normal speech and communication (20%) or that it would depend upon the person, type and extent of the mental illness (8%). A similar number of interviewees (20%) thought that there would be some general abnormality such as not making sense, 22% said that there might be an inability to speak, and 18% that speech might be irrelevant or contradictory. While no precedent for this expectation in previous research could be found, it was included in order to further determine the public's willingness to stereotype. This sample was not willing to even typify speech and communication to a very large extent (Table 3).

Expected Look/Appearance of Mentally Ill Individual

Nearly half (42%) of the interviewees expected normal, or no difference in one's, look and appearance, with another 10% saying that it would depend on the person, type and extent of mental illness. Twenty-two percent felt that one might look strange, bizarre or sloppy, but as in the expected speech and communication results, typifications were limited, if not non-existent, and stereotypes unfounded (Table 4).

Necessary Conditions for Mental Illness

The primary criterion which was given as a necessary

condition for mental illness to be attributed to a person was continued abnormal behavior for the particular person in their own particular situation (82%) (Table 5). Dangerousness to self or others (22%), difficulty or inability coping (20%) and a difficulty or inability functioning (20%) were the typifications yeilded most often. These results are practically identical with the findings of Star, the only known researcher to probe the necessary conditions. She had found a loss of cognitive functioning, loss of control to the point of violence and inappropriate behavior as the three major factors.

Expected Reactions to Mentally Ill Individuals

Over half of the sample (52%) expected that they would react in a sympathetic, supportive manner with concern and compassion, trying to talk with and help the person with their problems. This was qualified in most cases however with the statement that they would have to know the person fairly well in order to be so willing to help. Responses were overwhelmingly sympathetic, supportive, and inquisitive rather than negative or non-involved. However the relationship to and knowledge of the person would appear to be the critical factors in the reaction, as 32% expressed fear, anxiety and apprehension if they did not know the person, and 12% would leave or avoid the situation if they did not know the person. Twenty-two percent declared that their reaction would depend upon the severity of the mental illness and how well they knew the person involved. Other frequently cited reactions were feeling sorry and compassion (20%), curiosity or fascina-

tion (20%) and frustration or helplessness at one's inability to be of help (22%). There was little evidence to coincide with Star's finding that the public was fearful and threatened, except where the interviewees did not know the person or where they were dangerous or violent, something which was clearly indicated was not always the case with the mentally ill (Table 6).

Experience with, and Relationship to, those Labeled Mentally Ill

Those having had direct contact with individuals whom they labeled as being mentally ill comprised 88% of the sample (N=44), while the remaining 12% (N=6) had had no such contact (Table 7). With local and national mental illness prevalence estimates being from 1-10%, it becomes obvious that the sample is heavily over-represented with those in contact with mentally ill individuals. A total of 67 experiences were described, with 24 persons having had 1 contact, 14 having 2, 2 having 3, 1 having 4 and 1 having 5. Additionally, 17 interviewees listed "many" contacts which were unreported in the interviews.

Of the 67 experiences reported on, 13 were with a relative, 10 were with a close friend, 19 with a friend, 17 with an acquaintance, 5 with a client, 2 with a co-worker and 1 with a stranger in public. Thus, over half of the experiences (52.2%) were with someone very close, and another 43.2% were with friends.

Circumstances of Contact with those Experiencing Mental Illness

When asked how they determined that those they had had contact with were experiencing mental illness, interviewees, in 73.1% of the total experiences they had had, did so

through observation and talking with the individual and as a result determined so for themselves (Table 8). Other listed methods of determination were: report by others of actor's problems (32.8%), report by actor him/herself of own problems (26.9%), actor's suicidal attempt or inclination (23.9%) and the hospitalization or institutionalization of the individual (16.4%). It would appear that the interviewees felt confident in making the determination themselves, and received corroboration from outside sources only after they had done so.

Actual Behavior of Mentally Ill Individuals

Actual behavior of those with whom interviewees had had contact was examined in order to see whether it would be different to any extent from the expected behavior, and consequently begin to look at the reciprocal relationship between typification and actual experience. Severe depression and the general description of abnormal, strange, different and disturbed behavior were the most frequently cited typifications (41% of respondents having experiences). Others included difficulty/inability functioning, dangerousness to self or others, aggression and compulsive habits. Responses varied considerably more than in the expected categories, with a total of 198 (Table 9). The typification of the individual becomes refined and expanded or contracted as direct experiences accumulate. Because the experience-non-experience groups were artificially after-the-fact, it will not be possible to establish how the typification undergoes revision. All that can be said is that the data show it to be more narrow than the actual behavior.

Actual Reaction to Mentally Ill Individuals

Reactions were primarily sympathetic and supportive (Table 10). Those most often listen were: observation, talk, try to help (18.7%); sympathetic, care, be a friend (13.3%); and listen (11.3%). Negative and non-involved reactions were relatively non-existent. These reactions are practically identical with the expected ones. No disparity between existential and extrapolated attitudes appears to exist, barring the effects of retrospective interpretation.

Help Obtained for Individuals Experiencing Mental Illness

Of the 67 reported individuals experiencing mental illness, 40.3% were hospitalized, institutionalized or remanded to a treatment facility, and 26.9% saw a psychiatrist, counselor or other professional (Table 11). The remaining individuals either had no help (5.9%), or were aided by friends or a minister (2.9%), with another 2.9% being jailed.

Outcome of Individuals Experiencing Mental Illness

The majority of the reported cases (35.8%) recovered, while 11.9% were unknown as to what happened to them and 10.5% showed some, but not a significant amount of, improvement. 5.9% showed no improvement, 2.9% were deceased, and 1.5% were jailed (Table 12).

Summary and Conclusion

Given the small, unrepresentative sample, what do the data imply in light of the theoretical perspective and past research? Very little emerges within these preliminary categories of responses which can be described as stereotypes. Despite the fact that research in the past has used stereotypes with as little as 5% agreement (Mackie, 1973), it would appear that something more than 50% would be a more likely figure of agreement to utilize before calling a set of typifications a stereotype. The data here, though small, rarely show more than 30-40% agreement, and if then, only as a result, often, of combining responses into groups. There is no evidence here that even a secondary stereotype exists for this educated sample. Willingness to stereotype can be said to be non-existent. The contention that typification may be a more applicable concept to work with has been supported here. For the individual typifications provide a source of data that can still be theoretically significant, whereas the stereotype remains in doubt as to whether it in fact exists at all or is a construct of sociologists.

It is interesting to note that many responses to interview questions were frequently qualified with statements such as "it depends on many things", "it could go from extremely _____ to extremely _____", "it varies", "it's hard to say", or "some but not all". Some interviewees felt that mental illness was an illness peculiar to the very intelligent, while others saw it not limited to intelligence at all. It was felt to be caused by any number of things from heredity and organic brain disease to the complexity of daily living

and stresses. Many were hesitant to use the term mental illness at all, and were encouraged to substitute one which they preferred, such as disturbance, or none at all.

While most interviewees spoke openly of their experiences with friends or relatives who had been mentally ill, others were respected when they chose not to discuss these matters. Responses were spontaneous for the most part, requiring little probing beyond the questions being asked. Responses also were usually qualified with statements to the effect that a wide range of possible manifestations of mental illness existed, including some which were not readily discernable by outside observers. Words such as "extremish," "manifest," and "range" kept appearing in the discussions.

Often, unsolicited accounts of the interviewees own mental illness problems would be offered, and always an overriding interest in the research itself was expressed.

The presence of an interviewer with whom one could establish rapport in a non-threatening atmosphere most likely facilitated the relative ease with which interviewees spoke and responded. The first-hand acquaintance with one's object of research which Blumer has advocated appears to be most valuable in this type of research. In constructing categories and typologies from the typifications yielded by others, one can get a clearer idea of the intended meanings of those who are the source of the data by being physically present and being able to ask for clarifications, repetitions, etc. One cannot typify the typifications of others without some basis for confidence in the understanding of what others mean.

That stereotyping was not an applicable construct in this small sample is one example of the benefits of primary data collection. The interpretations which have been made here from the data are not finished products by any means, but they are an initial step to theory from grounded research.

Whether or not there has been a change in the public's ideas about mental illness since the days of Star, Nunnally, Cumming & Cumming and their successors is still undetermined. The differences which have been found here could be a function of the special characteristics of the sample, the open-ended instrument, the effects of time and social change, or the proliferation of mass media contributions to the education of the public. One response indicated that college had had a consciousness raising or horizon lifting effect on the person's conception of mental illness. No attempt has been made to generalize even about the sample as a whole, let alone the Fan district or larger population universes.

The societal reaction process within the respondents as they confronted individuals experiencing mental illness appears to have been a carefully utilized deduction. Interviewees assessed for themselves that the individual was experiencing mental illness when they knew the person well enough to observe them acting abnormally for their own particular situation, even when they had been told by others or the person themself that they were experiencing mental illness. A careful process of observation, recognition of abnormality, imputing causation, and considering alternatives and reactions was followed. The single most important factor contributing to their ascription of mental illness and ensuing reaction

appears to have been the respondent's knowledge of the individual (social and personal biography and their situation). No difference in typifications between those having experience with mentally ill individuals and those without was apparent. Additionally, any differences in individual typifications due to demographic characteristics or respondents were not evident, but the sample size was too small to assess with any accuracy.

It becomes apparent after preliminary research that further research which would be addressed to increasing response rates, sampling individuals with more varied socioeconomic characteristics, comparing data collection techniques which may be more efficient (such as telephone survey and mailed questionnaire), and refining the open-ended instrument is desirable. At this point, the grounding of concepts, propositions and theoretical schemes can begin where the current research has left off.

It would be valuable to combine the research design utilized in this endeavor with others which would continue to attempt to examine the social psychological process of the ascription of mental illness, and the events which transpire in the early, less formalized stages of the labeling process.

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Table 1. Definition of Mental Illness (Respondent N = 50; Response N = 150)

Category/Type of Response	Response Groups	Absolute Frequency	* % of Total Respondents	% of Total Responses
Synonym	crazy, insane, wacko, messed-up, flipped out, flip lid, lose mind, off deep end	11	22	7.3
Medical/ Psychiatric	psychotic	7	14	4.7
	schizophrenic	7	14	4.7
	manic-depressive	5	10	3.3
	neurotic	5	10	3.3
	paranoid	2	4	1.3
	catatonic	2	4	1.3
	sickness/illness like any other	7	14	4.7
Behavioral Description	unable to cope w. everyday life, problems, reality, emotions	28	56	18.7
	difficulty/inability functioning	14	28	9.3
	difficulty/inability relating to, or getting along with, others	7	14	4.7
	inability to conform to societal norms, expectations	7	14	4.7
	distortion of perception of, or loss of touch with, reality	5	10	3.3
Psychological Description	emotionally disturbed	5	10	3.3
	mental/psychological problem, impairment, deficiency	9	18	6.0
	nervous, upset, mixed up	3	6	2.0
	self-image/esteem/respect problem	1	2	.7
Verifiable Description	someone institutionalized, hospitalized, being treated, or professionally diagnosed	5	10	3.3
	someone in need of help (medical, psychiatric, social work, etc.)	5	10	3.3
Uncharacterized Description	many different things, many forms; depends upon the person & type of M.I.; can be temporary or permanent, mild or severe, undetectable or quite overtly manifested	15	30	10.0

* Due to multiple responses per item, percentage total does not equal 100.

Table 2. Expected Behavior of Mentally Ill Individual (Respondent N=50; Response N=158)

Category/Type of Response	Response Groups	Absolute Frequency	* % of Total Respondents	% of Total Responses
	unable to function day to day, make decisions, control one's life	10	20	6.33
Behavioral Description	aggressive, hostile, violent, dangerous to self/others	12	24	7.60
	unpredictable	8	16	5.06
	unable to get along w. others/fit in w. society	3	6	1.9
	unable to differentiate right from wrong	2	4	1.3
	obsessive/compulsive habits/acts	1	2	.63
	alcohol/drug abuse	1	2	.63
	unaware of own actions, surroundings; out of touch with reality	16	32	10.13
Psychological Description	unable to control emotions; overly/extremely emotional	12	24	7.60
	anxiety, stress, nervous, hyperactive, overly excited	9	18	5.70
	withdrawn	9	18	5.70
	severe depression	8	16	5.06
	irrationality	6	12	3.80
	self-preoccupied to the exclusion of all else	5	10	3.17
	paranoia; abnormal/unfounded fear	4	8	2.53
General Description	abnormal, peculiar, bizarre, inappropriate	12	24	7.60
	marked personality/behavior change	2	4	1.3
Uncharacterized Description	many different ways; depends upon person & type of M.I.; could be whole range	28	56	17.72
	don't know	2	4	1.3
	normal, no different, can't tell from others	8	16	5.05

* Due to multiple responses per item, percentage total does not equal 100.

Table 3. Expected Speech/Communication of Mentally Ill Individual (Respondent N=50; Response N=81)

Category/Type of Response	Response Groups	* Absolute Frequency	* * % of Total Respondents	% of Total Responses
	unable to speak	11	22	13.6
	irrelevant, contradictory	9	18	9.9
	incoherent	6	12	7.4
	constant, excessive, fast	4	8	4.9
Behavioral Description	inappropriate	4	8	4.9
	studder, slurred, slowed	3	6	3.7
	nonverbal; gesture, body movement	3	6	3.7
	talk to self, imaginary others	2	4	2.5
	lie, deceive	1	2	1.2
	limited, restricted vocabulary	1	2	1.2
General Description	abnormal (riddles, yelling out, not making sense, change subject)	10	20	12.4
Uncharacterized Description	depends on person, type & extent of illness	4	8	4.9
	normal, no different	10	20	12.4

* Due to collapsing of response groups, absolute frequencies do not equal total # of responses
* * Due to multiple responses per item, percentage total does not equal 100.

Table 4. Expected Look/Appearance of Mentally Ill Individual (Respondent N=50; Response N=78)

Category/Type of Response	Response Groups	* Absolute Frequency	* * % of Total Respondents	% of Total Responses
Behavioral Description	excessively neat	5	10	6.4
	stare, a "look" in the eyes	4	8	5.13
	inattentive, distant, eyes wander	4	8	5.13
	affected mannerisms	2	4	2.6
	rigid body posture	1	2	1.3
	shuffling gait	1	2	1.3
	frightened, lost	1	2	1.3
General Description	strange, bizarre, sloppy	11	22	14.1
	abnormal (haggard, thin, lack of expression, extremes)	7	14	8.9
Uncharacterized Description	depends on person, type & extent of illness	5	10	6.4
	normal, no different	21	42	26.9

* Due to collapsing of response groups, absolute frequencies do not equal total # of responses
* * Due to multiple responses per item, percentage total does not equal 100.

Table 5. Necessary Conditions for Mental Illness (Respondent N=50; Response N=140)

Category/Type of Response	Response Groups	Absolute Frequency	* % of Total Respondents	% of Total Responses
Behavioral Description	dangerous to self/others	11	22	7.9
	difficulty/inability coping w. problems, situation, life, reality	10	20	7.1
	difficulty, inability functioning in day to day situation	10	20	7.1
	unable to get along w. others/fit in w. society	8	16	5.7
	unable to communicate	5	10	3.6
	unable to care for oneself, help self	2	4	1.4
	alcohol/drug abuse	1	2	.7
	criminal behavior	1	2	.7
Psychological Description	unaware of own actions, surroundings: out of touch w. reality	8	16	5.7
	unable to control emotions; overly/ extremely emotional	6	12	4.3
	anxiety, nervousness	5	10	3.6
General Description	continued irrational behavior	6	12	4.3
	not making sense	4	8	2.9
	don't appear to be in control	3	6	2.1
	severe personality change	2	4	1.4
	extremely erratic behavior	2	4	1.4
Verifiable Description	someone hospitalized, professionally diagnosed	7	14	5.0
	if told by others	1	2	.7
	if actor asked for help	1	2	.7
Uncharacterized Description	hard to tell; not qualified	6	12	4.3
	continued abnormal behavior for particular person & situation (depends on person & situation)	41	82	29.3

* Due to multiple responses per item, percentage total does not equal 100.

Table 6. Expected Reactions to Mentally Ill Individuals (Respondent N = 50; Response N = 188)

Category/Type of Response	Response Groups	Absolute Frequency	* % of Total Respondents	% of Total Responses
	sympathetic, supportive; concern, compassion, talk, help (if know well)	26	52	13.8
	say & do things that will help	19	38	10.1
	try to get some help	11	22	5.9
	feel sorry, compassion, pity, badly	10	20	5.3
	suggest/convince that they have problems and need help	9	18	4.8
Sympathetic/ Supportive	careful what say/do; afraid to do wrong thing	6	12	3.2
	remain objective, calm, patient, tolerant, try to cope	6	12	3.2
	ask "what's wrong, not like you"	3	6	1.6
	care for their safety, hygiene	2	4	1.1
	"mother" them	2	4	1.1
	call professional if they asked for help	2	4	1.1
	visit them in institution	1	2	.5
	treat them as they wish to be	1	2	.5
Inquisitive	curious, fascinated; try to find out what's going on in their head	10	20	5.3
General	frustration, confusion, helpless, not know what to do	11	22	5.9
	ask others what they thought	2	4	1.1
	restrain if violent	2	4	1.1
	what did I do wrong	1	2	.5
	leave, avoid if violent or couldn't help (if don't know well)	6	12	3.2
Non-Involvement	not want to get involved, be bothered (if don't know person)	5	10	2.7
	ignore, wait for others to help	2	4	1.1
	only get involved to a certain extent	2	4	1.1
	look out for myself	1	2	.5
Uncharacterized	depends on severity & how well know	11	22	5.9
	wouldn't bother me, calm, not alarmed	6	12	3.2
	normal, treat like anyone else	5	10	2.7
Negative	fear, anxiety, apprehension (if don't know)	16	32	8.5
	uncomfortable, upset, freaked out	8	16	4.3
	embarrassed	1	2	.5
	how could you do this to me	1	2	.5

* Due to multiple responses per item, percentage total does not equal 100.

Table 7. Experience with, and Relationship to, Those Labeled Mentally Ill (Case N=67; Respondent N=44)

	Absolute Frequency	% of total respondents	% of total experiences
Experience:			
yes	44	88	
no	6	12	
# of experiences:			
1	24	54.5	35.8
2	14	31.8	41.8
3	2	4.5	8.9
4	1	2.3	5.9
5	1	2.3	7.5
many unreported	17	38.6	
TOTAL #	67		
Relationship:			
friend	19	43.2	28.4
acquaintance	17	38.6	25.4
relative	13	29.5	19.4
close friend	10	22.7	14.9
client	5	11.4	7.5
co-worker	2	4.5	2.9
stranger in public	1	2.3	1.5

Table 8. Circumstances of Contact with Those Experiencing Mental Illness (Circumstance N=124, Exp. N=67)

	Absolute Frequency	% of total Circumstances	* % of total # of Experiences
observation, talk, self-determination by observer	49	39.5	73.1
others report of actor's mental illness/ problems	22	17.7	32.8
verbal report by actor of own problems	18	14.5	26.9
actor's report/attempt suicide	16	12.9	23.9
actor hospitalized, institutionalized	11	8.9	16.4
professional contact with actor as patient, client	5	4.0	7.5
actor under psychiatric or other professional care	3	2.4	4.5

Due to multiple responses per item, percentage total does not equal 100.

Table 9. Actual Behavior of Mentally Ill Individuals (Respondent N=44; Rep. Case N=67; Response N=198)

Category/Type of Response	Response Groups	* Absolute Frequency	** % of Total Respondents	% of Total Responses	** % of Report Cases
Behavioral Description	difficulty/inability functioning; disruption of normal behavior	13	29.6	6.6	19.4
	violent, aggressive, destructive, rage	13	29.6	6.6	19.4
	argumentative, outbursts, threats	12	27.3	6.1	17.9
	suicidal	12	27.3	6.1	17.9
	compulsive habits (eat, smoke, talk, steal, guilt, music)	10	22.7	5.1	14.9
	staring, zombie-like or 'wild' look	9	20.5	4.5	13.4
	unwillingness/inability to care for self (eat, sleep, control body)	7	15.9	3.5	10.5
	talk of own problems, ask for help	7	15.9	3.5	10.5
	alcohol/drug abuse	7	15.9	3.5	10.5
	excessive, uncontrolled crying	5	11.4	2.5	7.4
	unaware of own actions, surroundings	2	4.5	1.0	2.9
	unwilling to admit problems, get help	1	2.3	.5	1.5
Psychological Description	severe depression	18	40.9	9.1	26.9
	fear, paranoia	9	20.5	4.5	13.4
	withdrawn, uncommunicative	8	18.2	4.0	11.9
	nervous, anxious, hyperactive, excitable	7	15.9	3.5	10.5
	fabricate people/events	7	15.9	3.5	10.5
	absent-minded, forgetful, preoccupied	2	4.5	1.0	2.9
General Description	abnormal, strange, different, visibly disturbed	18	40.9	9.1	26.9
	unpredictable, erratic, moody, skittish, changeable, lack of concentration	9	20.5	4.5	13.4
	inappropriate behavior (dress, act, touch)	8	18.2	4.0	11.9
	immature, childish	3	6.8	1.5	4.5
	irrational	2	4.5	1.0	2.9
	overly dependent on others	1	2.3	.5	1.5

* Due to collapsing of response groups, absolute frequencies do not equal total # of responses.
** Due to multiple responses per item, percentage total does not equal 100.

Table 10. Actual Reaction to Mentally Ill Individuals (Respondent N=44; Rep. Case N=67; Rep. N=150)

Category/Type of Response	Response Groups	* Absolute Frequency	** % of Total Respondents	** % of Total Cases	% of Total Responses
Sympathetic/ Supportive	observed, talked, tried to help	28	63.6	41.8	18.7
	sympathetic, cared, friend	20	45.5	29.9	13.3
	listened	17	38.7	25.4	11.3
	got help for them	8	18.2	11.9	5.3
	felt badly for them	6	13.6	8.9	4.0
	talked with others about them	5	11.4	7.5	3.3
	suggested help, counseling	5	11.4	7.5	3.3
General	cautious	4	9.1	5.9	2.7
	frustrated	3	6.8	4.5	2.0
	didn't know what to do	2	4.5	2.9	1.3
	remained objective, cool, patient	2	4.5	2.9	1.3
	frozen, could not move	1	2.3	1.5	.7
Non-Involvement	didn't want to be bothered, withdrew	4	9.1	5.9	2.7
	nothing; thought it not serious, or would pass	3	6.8	4.5	2.0
	couldn't bear it so I left	1	2.3	1.5	.7
	kept distance for own protection	1	2.3	1.5	.7
Uncharacterized	normal, no different	8	18.2	11.9	5.3
Negative	uncomfortable, unnerved, ill-at-ease, nervous, upset, freaked out	7	15.9	10.5	4.7
	irritated, impatinet, angry	4	9.1	5.9	2.7
	frightened, afraid	4	9.1	5.9	2.7
	emotionally drained, relieved when over	4	9.1	5.9	2.7
	less supportive as time went on	2	4.5	2.9	1.3
	difficulty adjusting to situation	1	2.3	1.5	.7

* Due to collapsing of response groups, absolute frequencies do not equal total # of responses
** Due to multiple responses per item, percentage total does not equal 100.

Table 11. Help Obtained for Individuals Experiencing Mental Illness (Respondent N=44; Reported Case N=67 Response N=78)

Response Groups	* Absolute Frequency	** % of Total Cases	** % of Total Respondents	% of Total Responses
hospitalized, institutionalized, treatment facility	27	40.3	61.4	34.6
psychiatrist, counselor, professional	18	26.9	40.9	23.1
nothing	4	5.9	9.1	5.1
physician	3	4.5	6.8	3.9
minister	2	2.9	4.5	2.6
friends	2	2.9	4.5	2.6
jail	2	2.9	4.5	2.6
don't know	2	2.9	4.5	2.6

* Due to collapsing of response groups, absolute frequencies do not equal total # of responses

** Due to multiple responses per item, percentage total does not equal 100.

Table 12, Outcome of Individuals Experiencing Mental Illness (Reported Case N=67; Respondent N=44; Response N=74)

Response Groups	* Absolute Frequency	** % of Total Cases	** % of Total Respondents	% of Total Responses
recovered	24	35.8	54.5	32.4
don't know	8	11.9	18.2	10.8
some improvement but not significant	7	10.5	15.9	9.5
still having problems	4	5.9	9.1	5.4
still institutionalized	4	5.9	9.1	5.4
deceased	2	2.9	4.5	2.7
left school, job; not heard from again	1	1.5	2.3	1.4
religious conversion, subsequent recovery	1	1.5	2.3	1.4
jail for murder	1	1.5	2.3	1.4

* Due to collapsing of response groups, absolute frequencies do not equal total # of responses

** Due to multiple responses per item, percentage total does not equal 100.

Table 13. Demographic Characteristics of Sample (N=50)

Characteristic		Range	Absolute Frequency	% of Total Sample	Mean
Sex:	Male		14	28	
	Female		36	72	
Race:	Caucasian		49	98	
	Black		1	2	
Age:	20-29		33	66	
	30-39		8	16	
	40-49	20-73	4	8	31.1
	50-59		3	6	
	60-69		1	2	
	70+		1	2	
Marital Status:					
	Single		34	68	
	Married		11	22	
	Separated		0	0	
	Divorced		5	10	
	Widowed		0	0	
Education:					
	some high school		1	2	
	high school graduate		3	6	
	some college		14	28	
	college graduate		16	32	
	some graduate work		8	16	
	graduate degree (s)		8	16	
Type of Residence:					
	own home		15	30	
	rent apartment		35	70	
Length of Residence:					
	0-02 years		22	44	
	03-05 "	0-48	15	30	6.6
	06-10 "		5	10	
	11-20 "		5	10	
	20+ "		3	6	

Table 13, cont. Demographic Characteristics of Sample (N=50)

Occupation:			
student	10	bookkeeper	1
secretary	5	court clerk	1
computer prog.	2	librarian	1
clinical psychologist	1	retired billing clerk	1
police dispatcher	1	store detective	1
security guard	1	boarding hse. manager	1
registered nurse	1	watchmaker	1
recreation therapist	2	social worker	1
personnel director	1	advertising copywriter	1
houseperson	2	transportation planner	1
university faculty	4	market researcher	1
restaurant manager	1	graphic artist	1
public administrator	1	retail buyer	1
teacher, spec. educ.	1	accountant	1
broker	1		
actor	1		
sales manager	1		

Total Sample Contacted:	500	% Total
Residents who had moved:	58	11.6
Return Acknowledge	107	21.4
No Response	335	67.

Return Acknowledge Sub-sample

Total:	107	% sub-sample	% total
No	31	28.9	6.2
Yes	76	71.	15.2
Interviewed	50	46.7	10.

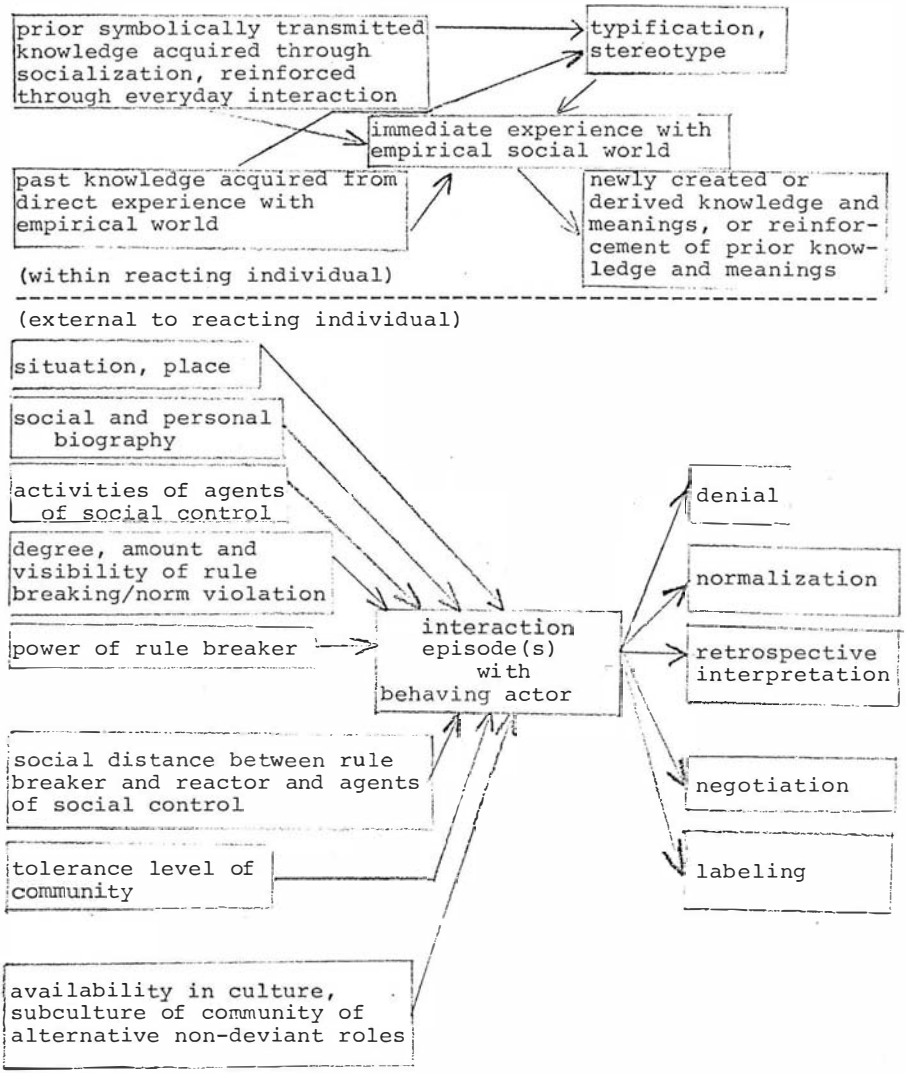
Table 14. Variable Response Frequency Distribution

Variable	1	2	3	4	5	6	7	8	9	10	11	12	Total # of Responses
Definition	9	13	11	7	7	2	1	0	0	0	0	0	150
Exp. Behavior	8	11	10	12	5	3	1	0	0	0	0	0	158
Exp. Speech/Com.	29	14	4	3	0	0	0	0	0	0	0	0	81
Exp. Look/Appear.	33	12	3	4	0	0	0	0	0	0	0	0	78
Necessary Conditions	9	15	11	11	2	1	0	1	0	0	0	0	140
Exp. Reactions	4	6	16	10	7	4	1	1	0	1	0	0	188
Experience	50	0	0	0	0	0	0	0	0	0	0	0	50
How Many	50	0	0	0	0	0	0	0	0	0	0	0	50
Many	50	0	0	0	0	0	0	0	0	0	0	0	50
Relationship	34	12	2	1	1	0	0	0	0	0	0	0	73
Actual Behavior	11	4	9	6	7	5	3	4	0	1	0	0	198
Contact Circumstances	18	9	14	7	0	1	0	0	0	0	0	1	124
Actual Reaction	12	7	13	10	6	0	1	1	0	0	0	0	150
Help Obtained	30	14	4	2	0	0	0	0	0	0	0	0	78
Outcome	32	14	3	0	1	0	0	0	0	0	0	0	74
Sex	50	0	0	0	0	0	0	0	0	0	0	0	50
Race	50	0	0	0	0	0	0	0	0	0	0	0	50
Age	50	0	0	0	0	0	0	0	0	0	0	0	50
Marital Status	50	0	0	0	0	0	0	0	0	0	0	0	50
Education	50	0	0	0	0	0	0	0	0	0	0	0	50

Table 14. cont. Variable Response Frequency Distribution

Variable	1	2	3	4	5	6	7	8	9	10	11	12	Total # of Responses
Occupation	50	0	0	0	0	0	0	0	0	0	0	0	50
Type of Residence	50	0	0	0	0	0	0	0	0	0	0	0	50
Length of Residence	50	0	0	0	0	0	0	0	0	0	0	0	50

Figure 1. Factors External to Behaving Actor Affecting Societal Reaction



Appendix 1

Contact Letter

Fellow Fan District Resident:

I am a graduate student in the department of Sociology/ Anthropology at Virginia Commonwealth University, and am presently completing requirements for a Master's degree under the direction of Dr. Joseph A. Marolla.

You have been randomly selected from the population of Fan district residents.

I would like to take about thirty minutes of your time by arranging to come into your home, and interview you concerning the topic of mental illness. The questions will not be personal or prying in any sense. Your responses will not be identified by name and will be kept confidential. I am interested in group effects, rather than information on individuals per se.

Please complete the attached post card and return it to me. I will contact you by telephone in order to set up a time most convenient for you, if you are willing to consent to an interview.

Thank you for your consideration, cooperation and assistance. Your effort will contribute to social science research.

Sincerely,

Kevin H. Ferguson
Dept. of Sociology/
Anthropology
Virginia Commonwealth
University
820 W. Franklin Street
Richmond, VA 23284
257-1028

Appendix 2

Return Post Card

Kevin H. Ferguson
Department of Sociology/Anthropology
Virginia Commonwealth University
820 West Franklin Street
Richmond, Virginia 23284

Please list your name, address and telephone.

Name: _____

Address: _____

Telephone: _____

Please check one:

* _____ Yes, I consent to be interviewed.

_____ No, I do not wish to be interviewed.

* What would be the most convenient time to call?

a) morning___ b) afternoon ___ c) evening ___

Appendix 3

Interview Schedule

1. When you hear someone say that a person is "mentally ill," what does that mean to you?

2. How would you describe a person who is mentally ill? (PROBES: How would that person act? How would that person speak? How else might the person communicate? What would they look like? What would their appearance be?

3. What tells you that a person is mentally ill?
(PROBES: What is necessary before you are willing to call a person "mentally ill?" What "proof" do you need to know that a person is mentally ill? Would they have to do this a lot? If they acted this way alone (in private), would you still be willing to call them mentally ill? Or if they acted this way in front of other people, would you be more willing to call them mentally ill?

4. If you found yourself in the presence of someone who was experiencing mental illness, what do you think your reaction would be?
(PROBES: How do you think you would act? What would you be feeling while you were in this person's presence? What would you be thinking?)

5. Have you ever had any direct contact with anyone who was experiencing mental illness?

   yes: _____ how many experiences? _____ no _____

   a) If yes, what was your relationship to this person? (role, social distance, power)

      - relative: _____
      - close friend: _____
      - friend: _____
      - co-worker: _____
      - acquaintance: _____
      - other: _____

   b) If no, skip to question # 12.

6. What were the circumstances of your experience, as best as you can recall?
   (PROBES: Where did this take place? work, home, in public, etc. What did the person actually do? How long had you known this person up to this point? Had you ever seen them do anything prior to this point in time that was unusual or strange?)

7. How long ago did your experience with this person take place?

8. How did you recognize that this person was having problems? (PROBES: What did the person do that told you they were mentally ill? Why do you think the person was acting the way they were? Did anyone else witness this person's actions while you did?)

9. How did you react to this person and their actions? (PROBES: Did you ever discuss this person's actions with another person while this was going on? Did you ever discuss this with the person themself? Did you think there were other possible ways that you could have reacted? Why did you choose the reaction you did?)

10. What help, if any, was obtained for this person?
(PROBES: What agencies, organizations or professionals were you aware of as being available for helping this person if they needed it?)

11. What became of the person?
(PROBES: Do you think the person could still be having any problems, or could have any in the future? Have they done anything since then that has been strange or unusual?)

12. Sex: a) male: _____ b) female: _____

13. Race: a) white: _____ b) black: _____ c) other: _____

14. Age:_____

15. Marital Status: a) single: _____ b) married: _____ c) separated: _____ d) divorced: _____
e) widowed: _____

16. Education: Highest level of schooling completed.

a) ___ 8 th grade or less

b) ___ some high school (____# of years)

c) ___ high school graduate or equivalency

d) ___ some college (____# of years; major:_____)

e) ___ community or junior college graduate (major: _____)

f) ___ professional, technical diploma program graduate (specify:_____

g) ___ college graduate (major: _____

h) ___ some graduate work (____# of years; major:_____)

i) ___ graduate degree(s) (specify: _____)

17. Occupation: In what occupation are you employed? (Be as specific as you can, e.g., physician, mail carrier, plumber, etc.)

_____

18. If different from question #17, in what occupation are you trained, or have you worked previously?

_____

19. a) Own house: ____ b) Rent house: ____ c) Rent apartment: ____

d) Live with family: ____ e) Other (specify: _____)

20. How long have you lived in the Fan? _____

Thank you very much for your assistance. You have been a tremendous help. I will make the results of this research available through VCU's library and Department of Sociology/Anthropology, and through the Fan Distric Association at the end of the summer, if you would be interested in the outcome.

Appendix 4

Subject's Consent Form

I understand that participation in this interview is completely voluntary, that there is no risk involved, and that I may withdraw from the study at any time.

I further understand that my responses will not be identified by my name in any written report and that they will be kept confidential.

I also understand that if, after having completed the interview or any part thereof, I should choose not to have my interview results included in the research, I may do so.

_____ _____

signature of interviewee date

_____ _____

researcher date

VITA