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NORC REPORT 51
(January 26, 1996)

Long held confidential in deference to its author Shirley Star, this report will now be made available on demand.

Plans exist to have a brief history of the project written by John Clausen who was a colleague of Star. As of date this has not been received (inquires will be made of Jack Elinson who is in contact with Clausen about this project).

Here's a summary of the materials available for Report 51.

ORIGINAL MATERIALS (these are in the bottom drawer as of date of the cabinet containing NORC numbered reports). There are multiple copies of some things.

1) Original Table of Contents with an asterisk (*) to indicate parts that we have.

2) Chapter 1: this appears to be draft (we refer to it a Draft Chapter 1) since large parts of it are now included in Chapter 3 (revised). We have copies of the original Chapter 1 with handwritten comments on it indicating that it is the old version, that it is revised, to see Chapter 3, and that the methods part of it were to be moved to an Appendix 3 (other places this is identified as Appendix A) which we don't have. Therefore, the methods portions of Draft Chapter 1 are unique as of date.

3) Chapter 3 revised. This contains much of the materials in Draft Chapter 1 except for the methods portion.

4) Chapters 4, 5, 6 and 9. These appear to be as written.

5) Tables: Original sets of tables mimeographed on legal sized paper. There is a first draft of tables 1 to 18 with hand and typewritten comments attached which indicate that certain tables were moved to the Chapter 3 revised and that all others were to have been moved to Appendix A (which we don't have).

Also found were Tables numbered 9-1 through 9-14.

There are also original copies of legal sized tables for Chapters 3 (revised), 4, 5, and 6.

PUBLIC VERSION OF REPORT 51 (These are in Report 51 file folder.)

A public version of the report was prepared which contains the following:

1) Cover sheet describing what's in the public version -attached.

2) Copies of Draft Chapter 1, Chapter 3 revised and Chapters 4, 5, 6, and 9,

3) Copies (reduced to standard sized paper) of the tables for Draft Chapter 1 that were to have been moved to Appendix 3 or A, tables for Chapter 3 (revised), 4, 5, and 6. Note that the separate Tables 9-1 to 9-14 have been inserted in their place.

The public version originals are in manila folders and can be used to prepare on demand copies. One complete copy is also in this file in a binder.

THE DILEMMAS OF MENTAL ILLNESS: AN INQUIRY INTO CONTEMPORARY AMERICAN PERSPECTIVES

By Shirley A. Star

(NORC Report no. 51, 1951+?)
(January, 1996)

This binder contains copies of the original version of this unfinished report which has heretofore not been made public by NORC.

Included are the original Table of Contents (an *indicates the parts that were finished and are included here), Draft Chapter 1, Chapter 3 (Revised), Chapters 4, 5, 6, and 9, and Tables for Draft Chapter 1, and Chapters 3 (Revised), 4, 5 and 6.

NOTES ON CHAPTERS AND TABLES:

Draft Chapter 1: This is the "original" Chapter 1 with the title "The meaning of mental illness" which was apparently to have been superseded by the Chapter 1 listed in the Table of Contents as "Public opinion and mental health goals: The relevance of public opinion; scope and method of the volume".

No evidence exists that a revised Chapter 1 was ever written. However, notes indicate that portions of the original Draft Chapter 1 were transferred to Chapter 3 (Revised). The original Draft Chapter 1 is included here for those materials not transferred to Chapter 3 (Revised), as indicated in the note on the first page.

Chapter 3 (Revised): "Popular perceptions of mental illness" is the largely revised version of original Draft Chapter 1, but it does not contain all materials in that chapter.

Tables: A set of Tables 1 to 18 (apparently for original Draft Chapter 1) exists with annotations that portions were transferred to the set of tables for Chapter 3 (Revised). The remainder were to have been transferred to Appendix A; however, Appendix A was apparently never created.

Therefore the tables intended for Appendix A have been retained in this volume and are marked accordingly. (For the record: Draft Chapter 1 Tables 1, 2, 3, 14, 15, 16, 17, 18 became Tables 2, 4, 3, 1, 8, 9, and 10 of Chapter 3 (Revised) tables. Intended for Appendix A and included in this volume are Draft Chapter 1 Tables 4 through 13 (which were slated to be Tables A-1 through A-11 of the Appendix).

Also found separately were Tables 9-1 to Tables 9-14; these have been inserted into the Chapter 3 (Revised) table numbering sequence.

NATIONAL OPINION RESEARCH CENTER
University of Chicago

Survey No. 272

THE DILEMMAS OF MENTAL ILLNESS

An Inquiry into Contemporary American Perspectives

Introduction (Author to be selected)

PART I. POPULAR PERSPECTIVES ON MENTAL ILLNESS

Chapter 1: Public Opinion and Mental Health Goals (The relevance of public opinion; scope and method of the volume)
(ORIGINAL CH. 1 INCLUDED FOR MATERIALS NOT INCLUDED IN CH. 3)

Chapter 2: The Dilemmas of Mental Illness (A non-technical, non-statistical summary of the entire study, together with consideration of its implications)

PART II. THE MEANING OF MENTAL ILLNESS

*Chapter 3: Popular Perceptions of Mental Illness

*Chapter 4: Popular Interpretations of Human Behavior: Six People in Action

*Chapter 5: Popular Interpretations of Human Behavior: Some General Features

*Chapter 6: Some Social Factors in Conceptions of Mental Illness

PART III. THE EMOTIONAL CONTEXT OF MENTAL ILLNESS

Chapter 7: The Course of Mental Illness: Images and Counterimages of Onset and Outcome

Chapter 8: The Threats of Mental Illness

*Chapter 9: The Status of Psychiatry

Chapter 10: In Conclusion: Social Responsibility for Mental Illness

TECHNICAL APPENDICES

A. Methods of Research

1. Development of the interview schedule; field procedures, including copies of questionnaire and instructions

2. Evaluation of the sample

3. Analytic techniques (methods of coding; technical notes of indices used in text)

B. Statistical Tables

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*First draft completed and included in this binder.

This is the original Ch. 1. Most of it is now in Ch. 3. However, the section on code building is not part of Ch. 3; it was to have been included in Appendix A which apparently was never prepared. See pages 17-36 for this material.

CHAPTER I

THE MEANING OF MENTAL ILLNESS

Introduction

Mental illness is not a term which has a precise, fixed, agreed-upon meaning, even in professional circles. The National Association for Mental Health, for example, divides the area of mental "ill-health" into mental illness, which includes only psychoses and severe psychoneuroses; other personality disturbances, which include mild psychoneuroses, psychopathies and a variety of personality and behavior disorders; and mental deficiency.[1] Most psychiatrists, on the other hand, would include all three of these categories under the heading of mental illness and might even add others.[2]

[1] The National Association for Mental Health, Inc. "Facts and Figures about Mental Illness and Other Personality Disturbances," April, 1952.

[2] See for example, R. H. Felix, M.D. and Morton Kramer, "Extent of the Problem of Mental Disorders," The Annals of the American Academy of Political and Social Science, March, 1953; American Psychiatric Association, Diagnostic and Statistical Manual, 1952.

These disagreements are, nevertheless, more apparent than real, for, however they are grouped, all of the general diagnostic categories subsumed under mental illness in its broadest usage are recognized by all professionals as disorders which require attention and which fall within the mental health field. Psychiatric diagreements over terminology and diagnosis have dealt not so much with setting these broad limits to the field as with problems of individual diagnosis, relatively

fine diagnostic distinctions and the borderline case. In fact, the term "mental illness" is not an important one within the mental health field, and little attention is given to the question of just what it includes. Since the general classes of disorders which concern the field are known and can be individually named, the tendency has been, instead, to refer to them collectively by some title which suggests their range and variety. Thus, the International List of Diseases and Causes of Death prepared by the World Health Organization now groups these disorders as "Mental, Psychoneurotic and Personality Disorders," and the American Medical Association's current Standard Nomenclature of Diseases and Operations refers to them as "Diseases of the Psycho-Biologic Unit."

In popular discourse, the term "mental illness" assumes importance, because it is the only way that people can refer, however imprecisely, to the range of phenomena which are regarded, professionally, as disorders of mental health. It is a remarkable and peculiar fact that there are no terms in common usage that can be used to refer to these disorders individually in a way that will be generally understood. Even if only the two most traditional categories of mental illness-psychosis and neurosis --are considered, the popular vocabulary has no words which unequivocably and unambiguously correspond to these concepts.

Popular speech does, of course, contain a number of colloquial terms--like "crazy," "nuts," "out of your mind," and, even, "insane"-- which are sometimes used as synonyms for psychosis, but these same expressions are so frequently heard in contexts where it is clear that their immediate intent is to express nothing more than transient disapproval of or disagreement with another person's conduct or ideas that it is not always possible to tell what is meant and what understood by their use. It is only when the operational criterion of actual or needed institutionalization is added to such epithets that they become relatively clearcut designations of psychosis, but, at the same time, they then apply to

a somewhat narrower range of disorder than that of the psychiatric category of psychosis. Since the course of a neurosis does not generally include a definite signalizing event like institutionalization, it is even more difficult to find ways of specifying it. Probably the most common popular approximation is the notion of "nervousness," but it is vaguely and diffusely applied to both a good deal more and a good deal less than is contained in the technical concept of neurosis. These difficulties in the way of communicating in the mental health field cannot presently be met by recourse to a more technical vocabulary. The imprecision and indefiniteness of reference of the everyday terms cannot possibly exceed either the general unfamiliarity of the public with such terms as neurosis and psychosis or the inexactness with which they are understood or employed by the minority who can recognize or pronounce them.

The ill-defined and diffuse qualities of popular conceptions of mental illness, the lack of general agreement about what mental illness includes and the absence of words which can be used to distinguish one way of delimiting mental illness from another--these are, to some extent, simply assertions that call for proof or disproof, and they anticipate, in rather dogmatic fashion, the empirical evidence of this study. Nevertheless, these conceptual and semantic difficulties must be mentioned at this time because they are not merely hypotheses which were confirmed by this research, but are, simultaneously, pre-existing conditions which made any exploration into popular views of mental illness singularly difficult.

The research difficulty was, simply, that ambiguity could not be directly avoided. When we talked with people about their ideas of mental illness, there was every likelihood that the term would mean different

things to different people, and there was no way to specify the term, mental illness, so it would mean the same thing to each person. Instead, the undefined term had to be employed with the recognition that people were not necessarily talking about the same thing, even though all of them were expressing their views of mental illness. In essence, we could only talk with people about mental illness when mental illness was left a term of undefined reference, but, so long as it was undefined, we could not meaningfully interpret what was said.

Since the study would be pointless under these conditions, an indirect approach that would eliminate ambiguity had to be found. The procedure adopted was to find out, in each person's own words, exactly what he meant by mental illness and, especially, how he would describe the symptoms of mental illness.

The limits of inclusiveness of each person's usage were then tested explicitly, by asking directly whether his usage included or excluded a variety of syndromes, some of which were labelled and others of which were described rather than identified. From this account, each person's conception of mental illness could be roughly translated into the technical categories of mental illness that appeared to be included in his usage. By means of these approximate translations into terminology whose meaning can be kept precise and unvarying from person to person, it is possible to specify the different ways in which different persons defined mental illness and the extent to which people adhered to internally self-consistent views of mental illness, even though their usage might differ from other people's.

Thereafter, the semantic difficulties resulting from the fact that mental illness does not have a common definition, could be avoided.

That is, any further statement about mental illness--its causes, treatment, prognosis, emotional connotations, etc.--was regarded as a statement applicable only to mental illness as conceived by the person making the statement and understandable only by reference to that individual conception. For example, if a person said that he was afraid of the mentally-ill, the knowledge that, for him, mental illness referred only to those psychotic syndromes in which violence is a prominent feature prevented the erroneous equating of this person with a person for whom mental illness included a variety of mild emotional disorders, but who was, nevertheless, fearful of the mentally-ill. In this instance, the seeming similarity of the attitude of fear of the mentally-ill concealed, because of a difference in terminology, a possible large difference in attitudes toward neurotics. In much the same way, a seeming difference in attitude could turn out to be a mere difference in terminology which concealed agreement in substance.

Given the necessity of this indirect approach, the ability to determine what people meant by mental illness is a most crucial phase of the research. Accordingly, this chapter is devoted to presenting, in some detail, the kinds of definitional and descriptive discussions of mental illness contained in the interviews and the way in which these were analyzed to obtain relatively clear-cut designations of variations in individual usage of the term.

First Impressions of Mental Illness

The concept of "mental illness" was, for most people, ill-defined and not at all clearly understood. They had some difficulty verbalizing about it at all and spoke rather haltingly in their attempts to formulate their ideas. In answer to the initial question,

> When you hear someone say that a person is "mentally-ill," what does that mean to you?
>
> (PROBES: How would you describe a person who is mentally-ill? What do you think a mentally-ill person is like? What does a person like this do that tells you he is mentally-ill? How does a person like this act?),

people usually began by replacing mental illness with an equivalent phrase like "mental sickness" or "sick in the mind" or by using labels or summary characterizations that were so vague or so general as to be meaningless. It usually required repeated questioning and exploration to obtain answers formulated in terms concrete enough to convey some sense of the person's conception of mental illness. Here for example, are a few typical answers:[3]

---

[3]Whenever answers are quoted in this report, they are a strictly random selection from among all answers in that category. Any other method of selecting illustrative quotations carries with it the danger that only the more striking answers or only those most in line with the interpretation being advanced will be cited. The intent here is always to convey, without bias, the flavor of the original data, although it must be recognized that their range and variety cannot be fully captured in the limited number of illustrations that can be included.

> It means that they are mentally sick. (P.)
> He's abnormal in his behavior. (C.)
> He says peculiar things and acts noticeably different from other people. (C.)
> Being unusually moody, being worried all the time over real or imaginary troubles, always thinking there's something wrong with his health.[4]

---

[4]The parenthetical symbols represent questions asked by the interviewer after the original question. "P." indicates that one of the probes suggested in the question was used--for instance, "How does a person like this act?"--or that additional description was requested--e.g., "How else does he act?" "C." indicates that the interviewer's question asked for clarification of what had just been said--e.g., "Abnormal? How do you mean?" or "Could you give me an example of that?".

Nuts in the head. (P.) It's a mental derangement where his actions are below normal and they have no control of themselves.

Well, the man is not doing things the way he should; he's unbalanced. (P.) Well, he would be irritable for little or no reason. (P.) He'd have a bad memory, forget things easily. (P.) He might be spiteful--he might show signs of bad habits. (C.) Spitting on the floor of his own house. I knew someone who did that. (C.) He'd spit on his own living-room floor, not caring at all. (P.) He's the only one I know. (P.) I think that they'd hurt others and not care at all. (C.) Insult them. (P.) Not that I know.

Insanity. (P.) Imagination. (C.) They imagine they have money hidden somewhere. (P.) They talk about it. (P.) They think people are after them.

Someone who has a sick mind. (P.) By talking strange and acting strange. (C.) By doing things that seem out of line with normal behavior. (C.) Reacting to a thing that is of little consequence and he will make a big thing of it, and talking all the time about it so he wears everyone down with it and you want to get away from him.

They are disturbed in their minds. (P.) Not able to cope with life. (C.) Where they are so disturbed they can't carry on like the rest of us. They can't see things as they are.

Most affected, I imagine, in the brains, ain't it? I don't know. (P.) He just don't think right or do normal things. (P.) He's just nervous, I imagine, and can't think straight. Some of them when they're mentally sick want to fight, and some of them don't know what they're saying. They'll just say anything.

They are unable to carry on a normal life. (P.) They generally are incoherent in their talk and thoughts. (P.) They have dilated eyeballs.

A great depression of spirits. (P.) Easy tasks become difficult. (P.) A feeling of fear without reason. You lose all zest for living, no pleasure in anything.

Not all the time, mentally /ill/, just nervous--some worse than others. I'm a nervous type myself. It's from change of life or, sometimes aggravation. (P.) Sometimes they say things they shouldn't. They just go around and don't bother anyone. They keep on talking. They could be cured. (P.) There are different kinds of mental sickness. (P.) They go around and don't bother anyone. (P.) Sometimes they won't talk to people, lock themselves in, want to hit someone.

> A nervous, jittery person. (P.) He acts like us; he'd have to be very intimate to really know what's the matter. (P.) They're not crazy, so they act like us; only a doctor could really tell something was bothering them.

In all, close to half the answers (47 per cent) contained "rough-and-ready" references to diagnostic categories like the "nuts in the head" and the "nervous type" in the preceding quotations. Just over half (54 per cent) made vague summary characterizations, as exemplified by the undefined use of words like "abnormal," "peculiar," "different," and "unbalanced" in these illustrations. Sooner or later, however, the large majority (81 per cent) were able to speak, in more concrete terms, of what they meant by mental illness. In terms of completeness of answer, then:

> 4%...said only that they could not describe mental illness.
>
> 15%...spoke only in terms of popular diagnostic equivalents or summary characterizations, or both.
>
> 63%...began in these general terms, but progressed to the particular.
>
> 18%...spoke in concrete terms throughout.

While these results do indicate the halting and tentative way in which most people spoke of mental illness, they do not adequately convey the content assigned to it. In order to get a fuller sense of what people were talking about and to follow the procedure by which conclusions about their ideas of mental illness were reached, the concrete elements in these discussions must be examined in some detail, even though their variety and diversity tend to produce a kaleidoscopic impression. Without this familiarity with the original data, however, it would be impossible to evaluate the justifiability of the interpretations made of them and the credibility of the conclusions drawn.

The most frequently used diagnostic category was made up of the previously-mentioned popular terms suggestive of psychosis. Close to one-fourth of all persons--just about half of those who referred to diagnostic categories at all--made references suggesting psychosis in these terms, while references to nerves, nervousness or nervous disorders followed close behind. Much less frequently, there were mentions of non-psychotic disorders generally--usually in the oblique form of "not all of them are crazy" or "some are out of their minds, but some are not," of nervous breakdowns, and of neuroses or emotional and personality disorders. If all four of these categories, suggestive of non-psychotic syndromes, are combined, then about one-third of the public (or two-thirds of those who used diagnostic categories) appeared to be including non-psychotic syndromes within their concept of mental illness. (See Table 1 for more exact detail.[5])

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[5]All tables are presented in Appendix

These figures cannot be taken at their face value, of course. Doing so would presume for these popular diagnostic terms a precision of reference which they can be shown to lack. As a first approximation of the popular meaning of mental illness, however, they do indicate what the people who used them <u>said</u> they were talking about under the heading of mental illness. What they <u>were</u> talking about is, however, better inferred from the descriptions people gave them from the labels they attached to their descriptions.

Essentially, summary characterizations of mental illness were of two types, the one stressing "mental" and the other, "illness." (See Table 2.) Where the emphasis was on "mental," as it was for 58 per cent

of those who spoke in summary terms, the mentally-ill were regarded as deviating from the norms of rationality, consistency and control in thinking and action. The degree of departure from these norms that was attributed to the mentally-ill varied all the way from the legal concept of incompetence to the feeling that the mentally-ill were undependable, changeable or impulsive:

> They are out of their mind and don't know what they are doing or saying.
>
> They just don't have their right mind and do all kinds of things that don't make good sense.
>
> They might be confused and do erratic things.
>
> They are irresponsible--you couldn't depend on them to do anything or couldn't be sure they would carry it out.
>
> They become no good to themselves or anyone else. They're just not "at" themselves--they're off, mentally not responsible.
>
> They do things that people don't do normally. They are not reliable.
>
> You never know from one minute to the next what they are going to do.
>
> They are mentally unbalanced, abnormal. (C.) They are childish.
>
> They can't always control their thoughts and actions.
>
> He would be disorderly in conduct.
>
> They seem to have very little control over their emotions.
>
> They are either way up or way down.
>
> I'd say, very emotional and they do things to excess.

Where the emphasis was on "illness," the mentally-ill were characterized as generally disordered or deviant, without reference to any particular norms that they were perceived to violate. Over half the time, the standard of normalcy was left unspecified; for the rest, it was usually equated

with the social standard of "the way other people act" or, occasionally, with the intra-individual standard of "the way he used to act." For example,

> They just act a little odd.
>
> They are just peculiar.
>
> Some are kind of queer.
>
> He says and does crazy things.
>
> It means they are unbalanced.
>
> He does things a right person wouldn't do--silly things.
>
> He isn't suited to get along with the rest of us normals.
>
> They act more or less not like a normal person.
>
> They act strange, do things that seem out of line with normal behavior.
>
> They do things that under normal circumstances they would not do. You notice that they are changed from their previous conduct.

These summary ways of characterizing the mentally-ill are so general that, with the exception of the notion of legal incompetence, they might equally well be applied to the mildest instance of personality disorder or to the most severe instance of psychosis. Nevertheless the cumulative impact of their invariable stress on deviancy tends to create the impression that the people who used them had in mind more extreme deviation than their statements, taken literally, implied. This impression can, however, only be checked by turning from these abstract generalities to the more concrete description of specific symptoms.

The specific descriptions of mental illness, as might be expected, were quite diverse and were, in fact, classified into over seventy categories,

the details of which are shown in Table 3.[6] The major lines of emphasis

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[6]The classification of symptoms of mental illness employed here was deliberately designed to impose as little conceptualization on the way people talked as is consistent with the necessity of grouping into categories, on the basis of their similarity, answers which were, in some respects, unique. Like all systems of classification, it contains an element of arbitrariness, and alternate ways of grouping the basic categories into major classes are not only conceivable but may even strike the reader as more reasonable or more useful. The main advantage of this mode of classification is just that these alternatives are available; the source materials are not inflexibly constrained to any one way of conceptualizing them. The preservation of so much of the concrete detail makes it possible to combine categories along the lines of any method of conceptualization one may wish to apply, and the relation of a particular conceptualization to the empirical evidence is fully exhibited. In contrast, an initial classification in terms of a conceptual scheme at a level of abstractness remote from the plane at which popular discourse took place is much more rigid; once the concrete materials are so ordered, they cannot conveniently be translated into a different ordering system, and only the original classifier can know precisely how adequately the conceptual scheme fits the concrete depictions it is intended to organize.

---

were:

1. Disordered emotional tone. Slightly over a third of the public described symptoms which centered around the individual's subjective state or mood. The stress here was on the familiar pattern of irritability, sensitivity, anxiety and depression, with less frequent references to withdrawn, apathetic and indifferent attitudes. Illustratively:

> That's only a nervous ailment. (P.) He worries--that's all it is.
>
> It means a person is worried. (P.) They get upset so easily. (P.) Well, you know, they are nervous.
>
> They seem to be extremely upset over things. (P.) I really don't know. (P.) They cry easily and get furious over nothing.
>
> They are offended easily and fly off the handle.
>
> They're fussy, cranky and irritable.
>
> Nervous, high-strung, erratic people are mentally-ill. (P.) Sort of impulsive, sort of flighty. (P.) I don't know. (P.) I think they're depressed.
>
> They might be quiet and melancholy.

2. Intellectual impairment. About as frequent as reference to emotional disturbance were comments on impaired thought processes.[7]

---

[7]For the sake of clarity, symptoms attributed to mental deficiency and to conditions not generally classifiable as mental illness were disregarded. These intellectual types of symptoms and all other symptoms described were, therefore, attributed to forms of mental disorder other than mental deficiency.

These tended to assume a more extreme character than did the references to mood, however. Foremost in this category, and the most frequently mentioned symptom of any class, were references to the incoherence, irrationality and incomprehensibility of the talk and conversation of the mentally-ill. This "inappropriate talk," together with lack of comprehension and major disorders of memory and orientation, dominated over half the descriptions of intellectual impairment. In a less frequent version, the intellectual impairment was perceived as much more moderate--a kind of impaired performance or efficiency growing out of brooding, preoccupation, or obsession and taking the form of absentmindedness, forgetfulness, or a decreased ability to concentrate. For example:

> Well, it seems their mind is not right. (P.) They don't recognize anybody and don't seem to know what they are doing--no presence of mind.
>
> They talk irrationally and don't remember things.
>
> Their mind is not right--not active. (P.) By his everyday actions. He's not active, doesn't perform his daily duty. (P.) They can't keep on the subject --jump from one thing to another.
>
> This dentist would neglect his business and he would talk out-of-the-way.
>
> Their conversations are not quite normal. They talk incoherently.
>
> You would notice their being absent of speech, being nervous, forgetful and childish. He dwells on one subject, thinks just one way.

> They are not adjusted to combat every-day life. They are nervous and probably wool-gatherers.

3. Distortion of reality. About a quarter of the public described degrees of misinterpretation of themselves and of the world around them as characteristic of the mentally-ill. These ranged from delusions, hallucinations and a frank break with reality to more frequent references to attitudes of distrust and suspicion, hypochondriacal tendencies and more generalized readiness to perceive events subjectively and reject or ignore inacceptable facts. For instance:

> I would think that they thought they were insane. (P.) They imagine things that are not true. (C.) Such as thinking people will kill you. (P.) They might hear voices.

> He's queer. (C.) Suspicious of most people, always looking for trouble and imagines pains and aches.

> Lots of times they think they're sick and then they get to worrying, and this really does make them sick.

> They have an ill-adjusted life. (C.) Either they haven't grown up or they can't face reality.

> They are the last ones to admit it. They don't recognize it in themselves.

4. Deviant external appearance. About a fifth of the public made references to the external appearance of the person, roughly half of these comments being descriptions of tension, restlessness and inability to relax together with accompanying tremors and tics. The other descriptions in this category took the more extreme form of stuporous, trance-like states, postural oddities, a peculiar look in the eye, and the like:

> It's a nervous condition that makes them just go all to pieces--nervous, shaky, may shake the head or some other part of the body.

> Their actions are nervous and jittery; some pace the floor.

> The ones that go crazy, they stare. (P.) They just stare and are kind of numb.

> I imagine they don't walk or talk like everyone else. They have a queer look, a dazed look out of their eyes. (P.) Most of them let themselves go, won't shave or clean up.

5. Violent acts. About one person in seven made reference to acts of violence--self-destruction, homicide and the like:

> They are nervous. (P.) They might try to commit suicide. (P.) They might kill other people.

> Sometimes they get awful violent and try to hurt somebody.

> They could harm themselves--hitting themselves against walls--or cause fires.

6. Violent, extreme expression. One person in ten described uncontrolled, extreme or violent expression of emotions as characteristic of the mentally-ill, referring chiefly to excessive weeping, tantrum-like rages, and meaningless laughter:

> They laugh or cry often, want to be alone a lot, hide from people, and scream.

> Sometimes they cry a lot and walk the floor, and it seems like they want to scream and do sometimes.

7. Disordered self-image, character traits. One person in ten attributed to the mentally-ill a variety of personality characteristics which had in common a disordered conception of self. Thus, the mentally-ill might be described as chronically dissatisfied and complaining, as egocentric and overly-demanding, as self-pitying and martyred, as insecure, as self-righteous, or as overly-submissive:

> The only one I knew carried on and bothered everyone to do things. (C.) By carrying on I mean she complained loud and long and wanted to be waited on.

> They let their emotions get the best of them. (C.) They expect a lot of sympathy and they worry. (P.) It's mental illness when he starts feeling sorry for himself and trying to get sympathy.

8. Health impairment. One person in ten described physical symptoms like chronic fatigue, loss of appetite, insomnia, and so on as accompanying mental illness:

> They are sick all over, think they are going to die, can't sleep and nervous.

> Some of them are tired all the time. They can't sleep, can't work. They have indigestion or a nervous stomach.

9. Speech mannerisms, disorders. Still less frequently, people described speech habits like talking to one's self, refusal to speak, excessive or too little talking, rapid or retarded speech rates:

> He does curious things. (C.) Well he might talk to himself or might laugh a lot about things that ain't funny.

> Well, I hear they act sort of funny. (C.) So quiet, and sit and mope around, won't talk to you or else talk your head off.

10. Exceptional, unusual behavior. About one person in twenty gave illustrations of behavior that struck them as deviant. These ranged from the bizarre, almost uninterpretable acts of psychotics to instances of violation of cultural standards:

> Some of them won't leave their clothes on or they want to wear only certain things.

> Just pile stuff around like my wife does. She's not reasonable; she saves things that are just useless and piles them up in piles.

11. Anti-social habits. The final and least frequently mentioned group of symptoms was that involving violations of moral standards--alcoholism, drug addiction, criminality, delinquency and sexual deviancy:

> It's not necessarily insanity. Alcoholism is mental illness. (C.) He's looking for escape and may turn to drink or dope or may just give up and allow himself to become mentally-ill.

With this highly concrete classification of symptoms, it is probably still difficult to form a very clear impression of the way in which people conceived of mental illness. It is apparent, in a general way, that many of the descriptions asserted or implied a degree of impairment difficult to associate with any mental illness short of psychosis, but a more exact assessment of the extent to which mental illness evoked an image of one syndrome rather than another requires a greater compression of the wealth of detail than has so far been presented.

A first approximation to this generic image of mental illness was made by reading each discussion as a unit and trying to judge from the entire content what syndromes, conceived in broad terms, had to be postulated to account for the particular set of symptoms and other comments offered by a given person.[8] That is to say, the question was

[8]These judgments were made by coders with training in clinical, abnormal and social psychology and familiarity with psychiatric concepts.

what diagnostic category or categories the comments could be referred back to in order to relate all the descriptive items to syndromes in which they might plausibly occur, with the provision that this process of imputation should postulate as few categories as possible in accounting for the details of the answer and should avoid substituting assumptions about their meaning for the manifest meaning of the comments. An example will probably help to clarify the procedure used. Here, for example, is a complete answer cited earlier:

> It means that they are mentally sick. (P.) He's abnormal in his behavior. (C.) He says peculiar things and acts noticeably different from other people. (C.) Being unusually moody, being worried all the time over real or imaginary troubles, always thinking there's something wrong with his health.

For this illustration, the decision was that a non-psychotic syndrome was being described.[9] It should be noted that assumptions could have

[9]The usage followed in this study does not correspond exactly with any of the technical nomenclatures of mental illness, because the data did not permit the relatively fine distinctions needed to approximate technical usage. The term, non-psychotic syndrome, as used here, actually includes the categories of psychoneurotic disorders, psychophysiologic autonomic and visceral disorders, those personality disorders classified as personality pattern disturbance, personality trait disturbance and special symptom reactions, and transient situational personality disorders, as these are defined in current official nomenclatures. In essence, then, it includes all non-psychotic mental disorders with the exception of mental deficiency and of sociopathic personality disturbances. The usage was arrived at by combining the category of psychoneurotic disorders with a category defined by the National Association for Mental Health as containing "people with symptoms of the same illnesses as ... the psychoneurotic, but who are able to carry on the ordinary functions of life most of the time although they may be doing so under emotional strain manifested in maladjustments of various kinds, and psychosomatic illness." ("Facts and Figures about Mental Illness and Other Personality Disturbances," April, 1952.)

been made about phrases like "abnormal in his behavior," "says peculiar things," "acts noticeably different from other people," that would have led to an imputation of psychosis, but their meaning in this answer was taken to be only what was stated when the person was asked to clarify his response. Essentially, then, the judgment about this particular answer was based on its last sentence. Even so, if one had assumed that "unusually moody" might refer to melancholia and that "imaginary troubles" might be an oblique reference to delusions, a judgment of psychosis might also have been reached, but this decision would have required more assumptions than the alternate decision of non-psychotic syndrome. While it is possible that this person may have meant his description to apply to both, the answer could be fully accounted for without postulating psychosis, and the more economical and simpler imputation was made.

This process of imputing the breadth of reference of people's concepts of mental illness is not in any way the equivalent of individual psychiatric diagnosis, of course, and should not be equated with it. In the first place, as the illustrative answers cited indicate, the information available was far from complete enough to permit diagnosis, even if it were desired to make second-hand diagnoses. But, in the second place, our goal was of a different order. The situation was, simply, that people could be presumed to have at least some vague image or stereotype of mental illness in mind as they talked, and the process was one of inferring from the particulars of their comments the most likely general image underlying them. It cannot be expected that the results achieved by this method will be perfectly accurate and precise, but they do offer a workable approximation of the direction of popular conceptions of mental illness.

These ratings of the inclusiveness with which the term, mental illness, was spontaneously used are shown in Table 4. As we see there, about a third of the American public appeared to be thinking of psychosis and about a quarter of neuroses and emotional disturbances,[10] while two-

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[10] This category is defined more precisely in the preceding footnote.

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fifths of the public talked in terms which the raters found too ambiguous to classify. Beyond these major groupings, there was an occasional tendency to include within mental illness a group of syndromes that have in common high social visibility; that is, about three per cent appeared to be describing either exaggeratedly eccentric types represented by misers, recluses and cultists or social deviants like criminals, alcoholics,

drug addicts and homosexuals. Still less frequently, the concept of mental illness appeared to contain mental deficiencies and a variety of illnesses and reactions not generally regarded as mental illness--epilepsy, spastic paralysis, momentary justifiable fear or anger, and the like.

The major shortcoming of these results is that they still leave the conceptions of a large portion of the public undefined. This difficulty was met by a second approximation, based on the relation of these initial ratings of inclusiveness to the three elements of description previously discussed. Since these relationships serve as well to delineate the criteria that coders were actually--though not explicitly--employing in making their initial impressionistic ratings, the full meaning and basis for judging the validity of these ratings are also involved.

First, then, ratings of inclusiveness of usage tended to follow people's own use of diagnostic categories, although the correspondence was by no means perfect. But, coders were least able to decide what people were referring to, when they used no diagnostic labels, and most able to do so, when they employed popular equivalents for psychosis. (See Table 5.) In general, when people said, in these popular terms, that mental illness meant or included psychosis, the rating almost always agreed with them--91 per cent of those who mentioned presumably psychotic synonyms were rated as referring to psychosis. In contrast, just over half (52 per cent) of those who used presumably non-psychotic terms were classified as clearly referring to non-psychotic syndromes. This difference is, for the most part, a function of the greater ambiguity of reference of the presumably non-psychotic terms--"nerves," "nervous

breakdown," etc.--in comparison with phrases like "out of his mind," "lost his mind," "had to be put away," etc. A third of the people who used these terms were, therefore, rated as being unclassifiable with respect to what they were including in mental illness, while some ten per cent of those who used them without additional use of psychotic labels were rated as actually referring to psychosis.

Despite this similarity between people's use of terms and judgments of what they were including in mental illness, the instances where judgment was left partially or completely undefined could not be resolved in the light of popular usage. In the first place, only some 43 per cent of the public offered an exhaustive listing of diagnostic categories--that is, used diagnostic labels without also stating or implying that other, unnamed syndromes were also included in mental illness, and, of these, two-thirds were rated as actually referring to exactly the syndromes they had named. More important, however, the rating procedure had already taken account of the use of diagnostic labels, and had included a deliberate policy of accepting people's use as accurate, in the absence of evidence to the contrary, with the exception that entirely lay terms, like "nerves," "nervousness," and "nervous breakdown," were regarded as having no inherent diagnostic reference.[11] Instances left unrated, after a person had used such

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[11] Instructions on this point said, in part, "Code what you believe, in the light of your superior knowledge, the respondent is including under the rubric of mental illness... However, if the respondent has answered by reciting /relatively technical/ diagnostic labels and if these are not clearly and unmistakably incorrectly used, take his word for it and code these."

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labels, therefore, implied that the rater had strong doubts about the

way in which the term was being used, but did not have sufficient evidence to make a definite decision. To disregard this warning signal and conclude that people were talking about whatever they said they were talking about would be circular and would entirely defeat the purpose of discovering what popular terms meant.[12]

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[12] It should be pointed out, however, that the procedure of favoring the popular labels in arriving at a rating of what people included in mental illness is only one instance of the essentially conservative approach followed throughout the study for the purpose of avoiding unwarranted conclusions. Coding instructions and interpretations always followed the basic assumption that the respondent's views were to be regarded as accurate and reasonable--as corresponding with technical usage and outlook and/or as consistent within themselves, if they could possibly be so viewed. The effect of this approach is, of course, to place the burden of proof on those who believed that people were generally misinformed and confused about mental illness. As a result, the bias in our conclusions, if there is any, is in a direction opposed to our basic hypotheses about what we would find to be the case and not in the direction of finding confirmation for what we believed, a priori. Our conclusions, therefore, extreme though they may seem, if anything minimize rather than exaggerate the extensiveness of misconceptions about mental illness.

The use of summary characterizations tended to be associated with a view of mental illness as psychosis. That is, those who were referring to psychosis in connection with mental illness were more likely to offer summary descriptions than were those who were referring to non-psychotic categories, although summary description was used about as frequently in connection with syndromes that were unidentifiable as it was with psychosis. For those who did use summary characterizations, incompetency tended to be associated with an image of psychosis, while a lesser degree of mental or emotional deviancy was mentioned relatively more frequently in connection with non-psychotic syndromes. As might be expected from the fact that clarification of undefined notions of deviancy would have led to their identification with one or the other

of the better-defined categories, general deviancy was not clearly associated with any particular image of mental illness. (See Table 6.) While the preceding relationships are based on raters' inferences about people's images of mental illness, much the same picture is obtained if summary characterizations are related to the diagnostic categories people used, as shown in Table 7. Whichever criterion is used, people who spoke of incompetency were most likely to be referring to psychosis while those who mentioned no summary characterization were least likely to.

As the summary data in Table 10 make clear, the inferential ratings differed from people's own terminology primarily in increasing the differential association of summary characterizations with diagnostic categories. The essential similarity in pattern, taken together with the greater discrimination obtained with inferential ratings, suggests that this association between diagnostic reference and summary characterizations is not a simple artefact of biases or assumptions with which raters operated. Rather, the case seems to be that the ratings tended to purify and sharpen diagnostically-differentiating criteria that were also employed by the public, but in a fashion attenuated by some popular confusion and ambiguity in the use of diagnostic labels.

Specific descriptions of mental illness were related in much the same way as summary characterizations to public images of mental illness. The categories of unusual or exceptional behavior and of violent acts tended to be mentioned in a psychotic context, while the categories of disordered self-image or character traits, health impairment, disordered emotional tone and deviant external appearance tended to evoke a non-psychotic image. The remaining categories of description--speech

mannerisms or disorders, intellectual impairment, violent or extreme expression, anti-social habits and distortion of reality--were not as clearly differentiating, although their likelihood of being associated with a psychotic rather than a non-psychotic image is in the order given. (See Tables 8-10.) Once again, the sharper relationship of these specific descriptions to inferred images in comparison with terms used tends to increase the impression that the inferential ratings employed the same unformulated criteria as the public, but did so in a more precise and consistent fashion.

Nevertheless, these relationships obscure some of the pattern because each broad class of description includes a number of frequently diverse elements. Yet, to examine the relationship of each of these seventy or more categories of symptom description to imputed or asserted images of mental illness would become quite complex. Instead, each specific category was rated according to whether it was judged to be predominantly associated with a psychotic syndrome, or with a non-psychotic syndrome, so that images could be examined in terms of the severity of symptoms associated with them.

This process of classifying symptoms was done quite independently of any knowledge of the way in which the symptoms related to diagnostic categories. It may best be thought of as a formalization of the implicit referring of symptoms to syndromes that raters used in arriving at conclusions about what people were describing. Still, it differed from the rating process in that the symptom was classified without the context of references to other symptoms and to diagnostic labels, summary characterizations, and asides about causes, treatment and friends who had been mentally ill, in the light of all of which the rater formed

his impression. Moreover, the rater had considered the symptom in all the concrete detail in which it was described, while the categories of symptoms that were classified, although relatively concrete, necessarily eliminated many of the nuances which might have affected the rater's judgment of the significance of a particular description.

The working classification of symptoms used is shown in Figure 1. Essentially, the procedure of classifying them consisted of asking, for each category, whether this symptom, by itself, conjured up an image of any syndrome, and, if so, which one. For many of the symptoms, the answer had to be that the symptom was not sufficiently distinctive, as, for example, suicidal tendencies may equally well be associated with neurosis as with psychosis. In other cases, the decision was that the symptom was ambiguous because its classification depended on the degree of the symptom, which either had not been clearly expressed by the respondent or had been obscured by the way the basic category was defined --vague references to reality distortion, on the one hand, and impaired judgment, on the other. All of these descriptions were classed as indeterminate.

It may, of course, be said that, from the standpoint of individual diagnosis, indeterminacy is characteristic of any single symptom, but, as suggested earlier, individual diagnosis is not at issue. The logic of the procedure may, perhaps, best be seen by considering the reasoning behind the classification of an illustrative descriptive category. The category of "unhappy, depressed," which is here classified as non-psychotic, is used as an example because the symptom is, obviously, one element in the depressive psychoses and, therefore, raises most of the questions about this kind of classification. The reasoning is that

Figure 1

WORKING CLASSIFICATION OF SYMPTOMS OF MENTAL ILLNESS

PSYCHOTIC SYMPTOMS	INDETERMINATE SYMPTOMS	NON-PSYCHOTIC SYMPTOMS
	1 Disordered Emotional Tone Apathetic, indifferent, inert Out-going, extroverted, elated	1 Disordered Emotional Tone Irritable, excitable, sensitive, upset Unhappy, depressed Worried, fearful, anxious Hostile, aggressive, difficult Withdrawn, introverted, asocial Defeated, surrendering, hopeless Secretive, self-concealing Inhibited, repressed, emotionally-inaccessible
2 Intellectual Impairment Inappropriate, incoherent talk Major memory disorder, disorientation Intellectually retarded, uncomprehending	2 Intellectual Impairment Obsessive, compulsive Complete inability to perform	2 Intellectual Impairment Distracted, absent-minded, forgetful Brooding, preoccupied Impaired performance, efficiency
3 Distortion of Reality Delusions Hallucinations Excessive phantasizing, break with reality	3 Distortion of Reality Distrust, suspicion, paranoid trends Inability to accept, face, adjust to, reality Lack of perspective, impaired judgment Lack of insight Vague and unspecified reality distortion	3 Distortion of Reality Hypochondriacal tendencies
4 Deviant External Appearance Peculiar facial expression Stupors, comas, trances Peculiarities in posture, walk	4 Deviant External Appearance Neglect of personal appearance Other and unspecified signs in appearance	4 Deviant External Appearance Tense, jumpy, restless, unable to relax Tremors, twitches, tics
5 Violent Acts Homicidal acts, tendencies Other and unspecified violence vs. people Destructiveness, violence vs. property Other and unspecified violence	5 Violent Acts Violent sex crimes Suicidal acts, tendencies, impulses	

6 Violent, Extreme Expression

Senseless, excessive laughter

6 Violent, Extreme Expression

Senseless, excessive weeping
Raging, screaming, tantrums
Noisy, loud, boisterous
Hysterics, unspecified

7 Disordered Self-Image, Character Trait

Critical, dissatisfied, complaining
Egocentric, self-centered, demanding
Martyred, self-pitying, feelings of rejection
Insecure, lacking self-confidence
Self-righteous, self-justifying, obstinate
Submissive, dependent, indecisive
Self-accusatory, self-blaming

8 Health Impairment

Chronic fatigue, exhaustion
Loss of weight, appetite
Insomnia
Headaches
Physical malaise, weakness, collapse
Other specific psychophysiologic disorders
Vague and unspecified physical illness

9 Speech Mannerisms, Disorders

Talking to self
Mutism, refusal to talk

10 Exceptional, Unusual Behavior

Wandering, running away
Instances of bizarre behavior

9 Speech Mannerisms, Disorders

Verbosity, excessive talking
Taciturnity, too little talking
Other speech disturbances

10 Exceptional, Unusual Behavior

Instances of culturally-unacceptable behavior

11 Anti-Social Behavior

Excessive drinking, alcoholism
Criminality, delinquency
Lying, falsification, misrepresentation
Sexual deviancy
Drug addiction

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depression alone would not lead to a diagnosis of psychosis, in the absence of other symptoms, or, to put it another way, the degree of depression involved in depressive psychosis would be likely to entail manifestations of depression of a more dramatic or noticeable kind than is involved in this mere description of mood. On the other hand, this kind of mood coloration is a very common element in the neuroses. Taken by itself, therefore, it evokes an image of a neurosis and is classified as non-psychotic.

While this procedure is not precise, it should be evaluated in terms of its effect on the conclusions drawn from this research rather than in abstract, theoretical terms. These implications can be stated most simply by examining what would happen in the case of a person who had actually described a depressive psychosis. If he had described not only this mood manifestation but other symptoms like disorientation or hallucinations, the rater would undoubtedly have judged him to be talking about psychosis and he would be classed as having described both psychotic and non-psychotic symptoms. If he omitted the other symptoms, the rater would probably either have classed him as referring to a non-psychotic syndrome or have been unable to make a judgment, and his symptom description would be classified as non-psychotic. In the first instance, there is no difficulty, since non-psychotic symptoms do occur within psychotic syndromes. In the latter instance, however, the procedure, in effect, has asserted that no description can be classified as psychosis unless there is relatively clear-cut evidence of psychosis, so that anyone who happened to omit the more distinctive elements in his description of psychosis would not be counted as referring to psychosis. In other words, the procedure employed is one more instance of the conservative approach in this research, where every effort was made

to avoid doing injustice to the state of public knowledge of mental illness. Since a tendency to equate mental illness with psychosis is a departure from technical conceptions of mental illness, a procedure which contained only the danger that this tendency would be underestimated was chosen in preference to other procedures which might have spuriously inflated it.

A more complete examination of the symptoms listed in Figure 1 will also suggest that, for much the same reason, the research employed a working image of psychosis which tended to equate psychosis with its more extreme forms. Only such symptoms as major intellectual deterioration, sharp break with reality, delusions, hallucinations, grimaces and posturing, stuporous states, violence, meaningless laughter, mutism and bizarre behavior were classified as psychotic, so that an image of the more severe, institutionalized cases tends to emerge. While we had sufficient psychiatric sophistication to know that mild or moderate psychotics were often characterized by far less extreme manifestations, it was, in practice, far too difficult to distinguish mild psychoses from non-psychotic syndromes in any way that insured that people would not unwarrantedly be classified as referring to psychosis. The non-psychotic image, as delineated by the symptoms assigned to it, has less of this stereotyped quality about it, and the picture that emerges from such symptoms as tension, irritability, anxiety, depression, preoccupation, dissatisfaction, egocentricity, physical symptoms and hypochrondriasis corresponds fairly well with the technical categories grouped under this rubric.[13]

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[13]It should be noted that the symptoms called "anti-social habits" which, considered by themselves, would probably be associated with the diagnostic category of psychopathies or sociopathic personality disorders, are assigned here to the category of indeterminate symptoms, because this diagnostic category was excluded from the non-psychotic category, as used in this research.

On the basis of this broad typing of symptoms, shown in Table 11, the question of what people meant by mental illness can be carried one step further. As might be expected from the similarity of premises underlying the two classifications, the relationship of severity of symptoms to raters' judgments of people's images of mental illness is close. Thus, of those who gave specific descriptions of mental illness, 87 per cent of the people who were rated as referring only to psychosis had mentioned psychotic symptoms, while only 7 per cent of those rated as referring only to non-psychotic syndromes had. (See Table 12.) While the severity of symptoms mentioned was not as highly related to people's own assertions about the syndromes they included within mental illness, symptom severity did, nevertheless, significantly differentiate among the diagnostic labels, and this relationship, presented in Table 13, does not contain the circularity involved in the preceding one.

Given this close relationship between type of symptom and rating of diagnostic reference, it was decided to use the type of symptom to resolve the classification of those persons whom the coders had been unable to classify. The major observation which can be made about the description of mental illness offered by people who had not been classified is that, consistently throughout the relationships previously presented, these descriptions fall somewhere between descriptions associated with psychotic syndromes and those associated with non-psychotic syndromes, whether the syndrome classification was based on people's own statements or on inferential ratings of what syndrome was intended. For instance, the group rated as referring only to unclassifiable syndromes is shown, in Table 12, both to have mentioned psychotic symptoms more frequently than those classified as referring to non-psychotic syndromes and to have mentioned non-psychotic symptoms more frequently than those referring

to psychotic syndromes. Or, quite similarly, the group rated as referring to both psychosis and some unclassifiable syndrome was between those classified as referring only to psychosis and those classed as referring to both psychotic and non-psychotic syndromes in differential use of the various descriptive elements--diagnostic labels, summary characterizations and specific descriptions.[14] It is apparent, from these descriptive similarities and contrasts, that the groups who were unclassified by the raters actually contained a mixture of the various possible points of view--a kind of averaging of the alternate possibilities. That is, the descriptions of mental illness given by the people rated as referring to unclassifiable syndromes were what would have resulted if descriptions given by people referring only to psychosis, people referring only to non-psychotic syndromes and people referring to both had been combined, and the descriptions of those classified as referring to both psychosis and an unclassified syndrome similarly approximated a weighted average of descriptions of psychosis and descriptions of both psychotic and non-psychotic syndromes.

These groups of fully or partially unclassified reference were, therefore, reallocated among the logical possibilities on the basis of the kinds of description they contained. The point of view adopted was that a reference to an unclassified syndrome was actually a reference either to psychosis or to a non-psychotic syndrome or to both, and that the best

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[14] The same observation can be made for the small category of people classed as referring to non-psychotic syndromes and to some unclassifiable syndrome, whose descriptions generally fell between those of people referring to both psychotic and non-psychotic syndromes and those of people referring only to the latter. In terms of the basic question of how many people restricted mental illness to psychosis, however, this group is already sufficiently classified and needs no further resolution.

way to decide which of these possibilities was most likely was to re-examine the description of mental illness accompanying it. These descriptions of mental illness, summarized as the severity of symptoms contained in them, were used to resolve the ambiguous cases by simply assuming that an unclassified syndrome associated with a given sympton pattern referred to psychosis, or to a non-psychotic syndrome or to both with the same relative frequency as the frequency with which each of these three clear-cut possibilities had occurred in connection with that symptom pattern.[15] Thus, the probability that unclassified syndromes referred only

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[15]It is possible to argue against the procedure used, that, if the type of symptom actually were so closely related to the diagnostic category being described, the raters would have classified each answer on the basis of the description of symptoms contained in it, and there would be no necessity for reclassifying any of them. That is, if a rater could not classify an answer which contained description of psychotic symptoms only, for example, it could be maintained that there must be something about that answer sufficiently different from one he could classify as psychosis to lead us to question whether the probability that the unclassified answer referred to psychosis should be assumed to be the frequency with which symptoms of that type were associated with psychosis among answers which were classifiable.

While it is not possible to resolve fully a question of this kind, the likelihood that an unreasonable assumption was employed is greatly reduced by an examination of the way in which raters proceeded. The data indicate that, for those answers which contained descriptions of the type classified as psychotic, raters generally made a definitive classification only when the person had also used popular equivalents of psychosis to explain what he was talking about. That is, answers where the symptoms and the use of diagnostic labels both gave the impression of psychosis, were fully classified by the raters 84 per cent of the time, and left unclassified only 5 per cent of the time, and in no instance did the raters' judgment completely reverse the respondent's use of diagnostic labels. On the other hand, where the description of psychotic types of symptoms was accompanied by the use of non-psychotic labels, 53 per cent of the answers were left unclassified by the rater, 12 per cent were partially classified and only 35 per cent were fully classified. In only 20 per cent of these cases did the raters' classification completely contradict the respondents' use of diagnostic labels. For the final possibility, where a description of psychotic types of symptoms was not accompanied by the use of diagnostic labels, raters also tended to avoid making a decision: 51 per cent were fully unclassified; 8 per cent were partially classified and 41 per cent were fully classified.

It appears, then, that raters tended to carry too far the basic research policy of assuming people's views were consistent and correct, whenever this interpretation was possible. Rather than classify a person as inconsistently referring to psychotic syndromes with non-psychotic labels or as limiting mental illness to psychosis, raters tended to avoid making any decision by leaving the syndrome unclassified, even though they were able to make a classification of essentially similar syndromes whenever their classification was in line with the person's use of diagnostic labels. In the light of this excessive caution on the part of the raters, the procedure used to eliminate unclassified instances appears to do little more than partially correct for this bias.

to psychosis and, consequently, the frequency with which they were re-assigned to psychotic category varied with the kind of description that accompanied them, all the way from almost 100 per cent of the unclassified cases described in terms of only psychotic symptoms to less than 4 per cent of the unclassified cases characterized by non-psychotic symptoms only. (See Table 14.) Similarly, cases classified as referring to both psychosis and to an unclassified syndrome were divided between references to psychosis only and references to both psychosis and non-psychotic syndromes on the basis of the relative frequency of these two possibilities within each kind of descriptive pattern.[16]

[16]For the reader who wishes to follow the procedure more closely, the entire operation is carried out here for the group whose descriptions included psychotic, intermediate and non-psychotic symptoms.

1) Original frequencies of diagnostic categories:

Psychosis only	103
Psychosis and unclassified syndrome	37
Psychosis and non-psychotic syndrome	51
Non-psychotic syndrome and unclassified syndrome	14
Non-psychotic syndrome only	23
Unclassified syndrome only	128
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2) Redistribution of "Unclassified syndrome only."

a. The total frequency of the three-possible clear-cut diagnostic references is 177 (103 + 51 + 23).

b. Therefore, the probability that unclassified syndromes were actually references to psychotic syndromes is .582 (103/177); to non-psychotic syndromes, .130 (23/177); and to both, .288 (51/177).

c. The 128 references to unclassified syndromes are reassigned according to these probabilities: 74 to psychosis (128 x .582), 17 to non-psychotic syndrome (128 x .130) and 37 to both (128 x .288).

3) Redistribution of "Psychosis and unclassified syndrome."

a. The total frequency of the two possible clear-cut references including psychosis is 154 (103 + 51).

b. The probability that a reference to psychosis and unclassified syndrome is a reference to psychosis only is .669 (103/154), and to psychosis and non-psychotic syndrome, .331 (51/154).

c. The 37 references to psychosis and unclassified syndrome are reassigned according to these probabilities: 25 to psychosis only (37 x .669) and 12 to psychosis and non-psychotic syndrome (37 x .331).

4) Redistribution of "Non-psychotic syndrome and unclassified syndrome.

a. Total frequency of clear-cut categories including non-psychotic syndrome, 74.

b. Probability of psychosis and non-psychotic syndrome, .689. of non-psychotic syndrome only, .311.

c. Reassignment of 14 cases of non-psychotic and unclassified syndrome: 10 to psychosis and non-psychotic syndrome, 4 to non-psychotic syndrome only.

5) Revised frequencies of diagnostic categories:

Psychosis only	103 + 74 + 25 = 202
Psychosis and non-psychotic syndrome . . . . . .51 +	37 + 12 + 10 = 110
Non-psychotic syndrome only	23 + 17 + 4 = 44

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The defensibility of this technique, however plausible it may sound, must be judged, in the final analysis, by how it disposed of concrete instances and whether these dispositions fit any reasonable conception of what should be classified as psychotic and what as non-psychotic. Accordingly, here are a few random examples of answers which had been regarded as ambiguous and the way in which they were reassigned:

Unclassified syndrome to non-psychotic syndrome

> The face constantly twitches in some cases. They're always thinking something is wrong. (P.) They have dizzy spells, are afraid to be alone. They're irritable all the time, not a pleasant person to have around.
>
> A sickness that can be cured, many times. (P.) I always think of it being a nervousness. (P.) Unreasonableness. (P.) Probably lack of memory. (P.) I suppose irresponsible actions, doing something for no apparent reason. (C.) In the one case I do know, the way she treated her relatives, she had taken a dislike to them.
>
> All kinds--it can be from a nervous condition, can be all different types. (P.) Some are depressed. (P.) Some are criminally inclined. (P.) They are the last one to admit it, don't recognize it in themselves. (P.) I can't think of anything else.

Unclassified syndrome to psychosis

> He has been sick and hasn't outgrown it. (P.) He's got a weak spot somewhere. (C.) Could be in a lot of places. (P.) By the talk. (C.) More not as sensible, like. (P.) Act more odd than other people would. (C.) A lot might be more childish. (C.) A lot wouldn't remember the way they should.
>
> Shows these symptoms by talking to themselves. (P.) They do funny things; they say funny things. (C.) They act irrational; they do the unexpected. (C.) Like shouting or screaming without provocation.
>
> Well to me it means some one who's not quite right in their mind. They act funny and talk funny and have queer ideas and all.

Psychosis and unclassified syndrome to psychosis

A nervous disorder and over-exertion--prolonged periods of exertion that create mental deficiency of the body. (P.) It depends on the stage--early symptom is a lack of thinking ability to know first that he is mentally-ill and therefore doesn't have the mental ability to help the condition and he'll get worse, to emotional collapse or lunacy.

My neighbor once started spitting from the mouth. They said she had a fit. Is that what you mean? (P.) The ambulance took her fast, she didn't do anything else except spit and roll on the floor. (P.) I know there's lots of crazy people in Bellevue, but I never saw any. I wouldn't go near such a place.

It makes me think their mind is impaired. It can be all the way from an extremely nervous condition to the violent stage. (P.) Well, they just act a little odd as far as the social outlook or a lot, compared to the seriousness of the case.

Psychosis and unclassified syndrome to psychosis and non-psychotic syndrome

Weakminded. (C.) They let things drive them to mental sickness. (P.) They are not responsible for their conduct or opinion. (P.) They cry a lot. (P.) It affects some in different ways--some are happy, everything is funny, others cry and are upset all the time. (P.) Sometimes the mentally weak become connected with too emotional a religion. In Columbia Hospital, some were driven nuts by drink. They were making noise all night. They gave them shots to keep them quiet. (P.) They are born with weak minds.

Somebody that isn't normal in their reactions to things around them. (P.) Various ways--I've known several that have been mentally-ill and they act in different ways. (C.) Quiet, docile, had nothing to say until he went off, then he talked, talked, talked on subjects that everyone was amazed he knew anything about. (P.) Others get mentally-ill, but they never have to go to institutions, yet their facilities are abnormally different than normal people.

I would say it's the older people, who sometimes get that way from old age, and younger people who have mental disorders. (P.) I've never seen anyone mentally-ill, so I couldn't say. (P.) They seem to be extremely upset over things. (P.) I really don't know, they cry easily, get furious over nothing.

From these illustrations, it once again appears that any errors of classification that may have been made were primarily in the direction of overestimating the extent to which the public included non-psychotic disorders within mental illness.

At long last, it is possible to summarize the meaning that mental illness had for people in their first groping attempts to formulate it. For at least half the adults of the United States, the spontaneous image evoked by the phrase, mental illness, was a picture of psychosis, in which extreme impairment of rationality and violent behavior were the two leading elements. As shown in Table 15, exactly 50 per cent were classified as referring only to psychosis in their discussion of mental illness, 12 per cent described both psychotic and non-psychotic syndromes, and 33 per cent appeared to refer only to non-psychotic syndromes, while one per cent described only mental deficiency or syndromes not classified as mental illness and four per cent were not able to formulate any description of mental illness.[17] Since these figures were deliberately designed to yield

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[17] A few of these people who described only non-psychotic syndromes said explicitly that they regarded the term, mental illness, as a contrast term to psychosis or insanity, used to refer to mental disorders short of psychosis; that is, "some people are crazy, but others are only mentally-ill." This point of view was so infrequently expressed that no attempt was made to determine exactly how often it occurred. Our impression is that the bulk of persons classified as referring only to non-psychotic syndromes would also have included psychosis under mental illness, had this point been raised.

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a conservative estimate, it is likely that this tendency to identify mental illness with psychosis was even more widespread than these data suggest.

The Status of Non-Psychotic Mental Illness

While the preceding section has indicated that, for a majority of the public, mental illness tended to call forth an image of psychosis, it

should not be assumed that this was, for the most part, a consciously-held view of mental illness. On the contrary, when the question of the identity of mental illness with psychosis was specifically raised, the overwhelming majority asserted that mental illness included more than psychosis:

> Would you say that everyone who has a mental illness is out of his mind...insane, or not?[18]
>
> | | |
> |---|---|
> | Insane | 10% |
> | Not insane | 83 |
> | Undecided, don't know | 7 |
> | | 100% |

[18] This highly colloquial terminology was used throughout the interview to refer to psychosis, as these were the phrases people were most likely to understand.

Even those whose spontaneous impression of mental illness included only psychosis, usually gave formal assent to the inclusion of more than psychosis within mental illness: 75 per cent of them accepted this broader view, while 16 per cent indicated that their view of mental illness was limisted to psychosis and nine per cent were not sure what they thought.

As described by those who believed that mental illness included more than "insanity," the illness of the "non-insane" mentally-ill was most frequently thought of as "nerves" or "nervousness," with less frequent reference to "nervous breakdowns" and emotional disorders. Summary characterizations were used less often than they had been in describing mental illness in general, but where they were used, there was a shift away from viewing the mentally-ill as legally incompetent toward such categorizations as uncontrolled and unstable. In terms of more specific description of symptomatology, the "non-insane" most typically emerged as tense, irritable,

anxious, depressed individuals, who were preoccupied with their problems and, consequently, forgetful and absentminded or hostile and difficult to get along with. There was, of course, a great deal of description that would not fit so well into the rather consistent neurotic syndrome just outlined, but this syndrome was the only one which merged with sufficient frequency to constitute some common core of meaning in diverse views of "non-insane" mental illness. To put some spark of life into this rather abstract summary, here are a few representative answers to the question, "What is the matter with the ones who aren't insane, then? (PROBES: How would you describe them--the ones who aren't insane? What are they like? How do they act?)"

> Nervousness. (C.) They might be sick physically; they would never be relaxed.
>
> I would say they're not insane or completely out of their mind, but I would say they can't seem to grasp the situation or meet it or sit down and reason out a problem. (P.) The ones that aren't insane, I would say are those people who had adjusted themselves and had been able to cope with any problem that has come up and who had been able to make a decent living and have no worry as to income that they have. (P.) To my way of thinking, they are easily aroused at the least provocation and become very violent. (P.) They're unusually sullen, not very talkative. (P.) Usually when asked a question their retorts are usually sharp and a "none-of-your-business" attitude, insulting.
>
> There are degrees and degrees. Some can carry on a very normal existence, they are not out of their mind continuously and they can live with the rest of the world. (P.) The insane should be in some institution.
>
> I think that something is bothering them that they have to clear up. (P.) They act nervous and upset.
>
> It's usually nerves. (P.) It could be a nervous breakdown. I never had much experience with it. (P.) I suppose they have wakeful nights, have loss of appetite, feel fatigued. (P.) They are tired out and depressed.

> Well, I'd say they are upset. (P.) Sometimes they are forgetful. (P.) They make other people miserable; they seem perfectly all right at times, then they get upset. (C.) I really don't know, I don't know anything definite to say.
>
> He has the kind of blood that needs cleansing. (P.) They can get relief from mental illness by confessing and helping themselves.

Taken as a whole, the descriptions of "non-insane" mental illness, which can be seen in more detail in Tables 1-3, were essentially the same as those which had been given for mental illness generally by the sub-group who said that their first descriptive impressions referred to non-psychotic syndromes. If Table 2 is compared with Table 7, it is apparent that summary characterizations spontaneously identified with non-psychotic syndromes were about the same as those given when a description of non-psychotic mental illness was explicitly asked for, once an allowance is made for the differential frequency with which this type of description was used at all in the two instances. Similarly, Table 3 in comparison with Table 9 and Table 11 in comparison with Table 13 indicate that specific symptoms of each type and degree of severity were ascribed to non-psychotic mental illness with the same relative frequency in spontaneous and directed descriptions.

The implications of this similarity are two-fold. First, it serves to underline the fact that the view of non-psychotic mental illness previously derived from the first impressions of the minority who spontaneously said that they meant to refer to non-psychotic syndromes was quite representative of the image of non-psychotic mental illness held by the majority of the public who had not made their inclusion of non-psychotic syndromes explicit, but who, when reminded, agreed to their inclusion. In other words, the contrasting popular images of psychosis and non-psychotic mental illness

that were derived from first impressions are not at all altered by a consideration of the manner in which the majority of the public thereafter tended to describe non-psychotic mental illness. By the same token, however, this general agreement on what entered into non-psychotic mental illness reinforces the conclusion that mental illness, when used as a term of general reference, tended to evoke a psychotic image. That is, when descriptions of first impressions of mental illness and of "non-insane" mental illness are compared, all of the differences are in the same direction as the differences in description of psychotic and non-psychotic syndromes. It is noteworthy in this connection that, among the vast majority who agreed that mental illness included more than "insanity," 45 per cent had described only psychosis in their first, spontaneous impressions of mental illness, while 50 per cent had included essentially non-psychotic description, so that the initial image of mental illness--even for those who knew better in a formal way--was, about half the time, psychosis.

This consistency in views of non-psychotic mental illness also implies that people sometimes included under the heading of "non-insane" mental illness essentially psychotic syndromes, just as they sometimes referred to psychosis by presumably non-psychotic terms. In addition to the 10 per cent who explicitly stated their limiting of mental illness to psychosis, there were some 13 per cent who, in practice, described only psychosis and two per cent who included psychosis as well as non-psychotic syndromes.[19] At the other extreme there were seven per cent who did not

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[19] These estimates of syndromes actually included within non-psychotic mental illness were arrived at through analysis of coders' ratings and symptomatology, using the same procedure which has been fully described in the preceding section. All of the qualifications and limitations indicated there apply equally here.

know whether they would include more than psychosis as mental illness, five per cent who agreed that mental illness should include more, but had no idea of what else it included and five per cent who could formulate non-psychotic mental illness only in terms of mental deficiency or of syndromes that would not generally be regarded as mental illness. In the final analysis, then, no more than three-fifths of the public (58 per cent) actually held a view of non-psychotic mental illness which approximated technical usage, and, as previously discussed, this figure must be regarded as a maximum estimate of the extent of public knowledge.

This conclusion is complicated by the use of the term, "insane," for it is possible to follow a legal usage whereby "insanity" applies only to the criminally or violently psychotic or to the legally incompetent, while all other psychotics are, by definition, not "insane." In point of fact, many of the people who did include descriptions of psychosis in their discussions of mental illness were, implicitly or explicitly, adhering to some such usage. Thus, only 13 per cent of those who included in their discussion of non-psychotic mental illness symptoms suggestive of psychosis referred to the category of violent actions, while 31 per cent of those who mentioned psychotic symptoms in their first impressions of mental illness made comparable references to violence. To put it another way, in the raters' judgment, 39 per cent of those who actually referred to psychosis under the heading of "non-insane" mental illness were describing non-violent psychoses--syndromes like senile psychosis, quiet, withdrawn catatonic states and the like, while 10 per cent referred only to the kinds of psychoses in which violence is a central feature, leaving 51 per cent who appeared to refer to psychoses generally or without regard to the violent-nonviolent dimension. In contrast, 79 per cent of the references to psychoses in first impressions of mental illness were in these general terms,

while 15 per cent referred to violent psychoses and six per cent to non-violent psychoses. Indeed, some 10 per cent of those who described psychoses under the heading of non-psychotic mental illness volunteered the statement that the presence or absence of violent behavior was the essential distinguishing criterion between the "insane" and the "non-insane" mentally-ill.

Nevertheless, the tendency to confound the psychotic with the non-psychotic was not, to any appreciable extent, a result determined simply by our having used the term, "non-insane," whose literal, legal meaning is not identical with non-psychotic, as though it were equivalent. In the first place, the general level of public understanding of mental illness--as the discussion up to now has begun to indicate--was not such as to make it likely that any appreciable segment of the public was aware of and used in their thinking about mental illness a nuance like the difference between psychosis and insanity. More directly, however, as a comparison of Table 4 with Table 5 suggests, the tendency to perceive only psychotic syndromes as mental illness even when presumably talking about non-psychotic mental illness operated to about the same extent when the ambiguity created by using the term, "non-insane" was not present. That is, people who labelled their first impressions of mental illness as non-psychotic, by the use of such terms as "nerves," "nervousness," or "nervous breakdown," applied these terms to syndromes which were actually essentially psychotic with exactly the same frequency as "non-insane" mental illness turned out, upon closer inspection, to be psychosis: in either instance, 17 per cent of those who described the syndromes they had in mind were actually describing only psychoses, while 73 per cent described non-psychotic syndromes.

What is apparent at this point is that, at best, only a bare majority of the American public used the term, mental illness, in a way which can be

regarded as roughly approximating its meaning and use in professional circles. That is, as an outside estimate, 58 per cent of the public explicitly acknowledged that mental illness included more than psychosis and, at the same time, had an image of non-psychotic mental illness which was consistent with what would technically be viewed as non-psychotic. The rest of the puglic divided between a small group who consistently adhered to a restriction of mental illness to psychosis only (about eight per cent) and a large group--34 per cent--whose views of mental illness already showed internal contradiction and confusion. Thus, there were at least nine per cent who, in practice, perceived and described only psychotic syndromes, even though they labelled and thought of them as non-psychotic. About four per cent described psychotic syndromes and weren't sure whether or not mental illness included anything else. Conversely, some four per cent thought that mental illness applied only to psychosis or weren't sure just what mental illness should include, despite the fact that they had described essentially non-psychotic syndromes. Or, again, some 10 per cent either could not describe non-psychotic mental illness or thought only of mental deficiency or of a variety of neurological disorders, even though some of them had described non-psychotic mental disorders, apparently without realizing they were doing so, in the first impressions of mental illness they gave. The complete interrelations of the three relevant questions--first impressions of mental illness, whether or not mental illness includes more than "insanity" and, where applicable, descriptions of "non-insane" mental illness are shown in Table 16, but it should be pointed out that this is not a final index of the extent of misunderstanding, confusion and inconsistency in popular use of the term, mental illness. On the contrary, it is simply intended to indicate that conceptions of mental illness began to fluctuate as

soon as more than one approach to the subject was made. As we shall see, continued exploration of the popular meaning of mental illness constantly expanded the amount and kinds of public misconception and confusion.

The Nature of Nervous Breakdowns

A somewhat different approach to the popular image of mental illness was made by specifically introducing into the discussion a term which has a good deal of currency--the "nervous breakdown." While it has been shown that the "nervous breakdown" was not actually one of the more frequently-used spontaneous terms of lay reference to mental illness, it was, nevertheless, widely recognized when mentioned, with some 95 per cent of the public able to offer some kind of description of it. Significantly, only one person in a hundred characterized the term as being too imprecise, ill-defined and non-technical to have any agreed-upon meaning.

In popular usage, a "nervous breakdown" was, generally, a term for a rather specific and acute syndrome. To the extent that its causes were discussed--and a surprisingly-large number (44 per cent) volunteered comments about its causes, a "nervous breakdown" resulted from overwork or from the pressures and strains created by such realistic life problems as economic difficulties and family frictions or from some combination of these two circumstances. The dominance of this point of view is indicated by the fact that, of those mentioning causes, 56 per cent referred to overwork, and 42 per cent, to realistic environmental difficulties; while the next most frequent causal category--that of physical causes other than overwork--was mentioned by only 16 per cent. (See Table .) This view of "nervous breakdowns" was frequently reinforced by imagery suggesting actual physical damage to or organic malfunctioning of the nervous system. Just about one

person in five (22 per cent) spoke of the nerves "becoming fatigued," "breaking down," "going to pieces," "shattering," "collapsing," etc. as the presumed mechanism by which the causal strains produced the ultimate symptoms. These strains, then, produced a condition of fatigue or a kind of weakening of self-control in which the person became extremely tense and unable to relax, quite irritable and easily upset, and given to unprovoked or excessive weeping, and the whole syndrome frequently developed to the point where the person collapsed and required a period of bed rest. (See Tables 2 and 3.) While comments about treatment were infrequent--only nine per cent volunteered methods of treating a "nervous breakdown," 75 per cent of these volunteered treatments consisted of rest, pure and simple, so that, while there was often an image of an acute breakdown, it tended to be viewed as a temporary episode that would subside once a person got enough rest to recover his strength or courage to face the many problems of life. The flavor of this popular view of "nervous breakdowns" can be seen in a few representative depictions:[20]

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[20]The question asked was, "As far as you know, what is a nervous breakdown? (PROBES: How would you describe it? What is it like? What happens to a person who has one? How does he act?)"

> Your nerves have gone to pieces. They can't function because they have been overdone.
>
> Some nervous breakdowns cause different ailments of the body. I don't think it always affects the mind completely. (P.) They can't sleep and can't rest. (P.) I think it can affect your heart and also the stomach--I've heard people say they had a nervous stomach. It can also cause you to have a rash on your body, a nervous rash--people are scratching.
>
> A person is overworked. (P.) A bad heart can cause it. (P.) Makes you nervous--your heart goes fast and it scares you and when you try to sleep your heart jumps.

> Just when you get all frustrated over the conditions of life and throw themselves down on the bed and can't carry on the battle. Then, the more you think on those things, the worse you get.
>
> I don't know, I've never known anyone who has had a nervous breakdown. (P.) Their nerves are just physically shot. (P.) No, their nerves are just shot completely--nervous exhaustion. (P.) They're so completely run-down that, whatever this condition was that brought it on, they just collapse completely. (C.) Mentally, they break down. It's something that has been bothering them; it grows and grows and they just snap. (C.) Their mind snaps; they need complete rest.
>
> Lots of things can cause that. Usually, it is a run-down condition. I would say more nervous breakdowns are caused from it. Small children have nervous breakdowns and it is caused from a run-down condition. (P.) Usually, they are sick or complain of being sick and are not able to go and do as they should.
>
> It's a person overworried. (P.) It's not the work it's the accumulation of too much worry with the work he has done. (P.) It's caused from improperly eating. (P.) He seems afraid or jittery, also sleepy all the time--he'd just rather lay down.

Although it is apparent that there was much less diversity and heterogeneity in the kinds of behavior included under the heading of "nervous breakdown" than was the case with mental illness, generally, or even with non-psychotic mental illness, it should not be assumed that there was public unanimity in using the term "nervous breakdown" to refer to the syndrome just described. In terms of our final rating of what was actually being described, "nervous breakdowns" emerged as an essentially non-psychotic syndrome for 72 per cent of the American public and slightly over half of this group appeared to be describing a syndrome in which physical malaise, fatigue or collapse was a central feature. At least 18 per cent, however, used the term to refer to the acute onset or recurrence of a psychosis, while two per cent described both psychotic and non-psychotic syndromes in discussing nervous breakdowns, three per cent described only mental deficiency or syndromes other than mental illness

and five per cent were not sufficiently familiar with the term to offer a description. (See Table 15.)

Despite their almost exclusive description of "nervous breakdowns" in terms that a person with technical knowledge would not hesitate to classify as mental illness, less than half of the public were willing to classify a "nervous breakdown" as mental illness:

"Would you say that a nervous breakdown is a mental illness or not?"

Is	48%
Is not	36
Undecided, don't know	16
	100%

And, oddly enough, people who explicitly assented to the inclusion of non-psychotic syndromes within mental illness were not very much more likely to regard a "nervous breakdown" as mental illness than were people who limited mental illness to "insanity"--50 per cent of the former group called "nervous breakdowns" mental illness, in comparison with 45 per cent of the latter.

The great paradox of the popular version of "nervous breakdowns" was that the more a person's description of them approximated the common "overworked-tense-uncontrolled" depiction, the less likely he was to classify them as mental illness. It may be seen in Tables 2 and 3 that the descriptions offered by people who said that "nervous breakdowns" were not clearly mental illness somewhat less frequently contained references to these symptoms. More directly, however, if a mention of either physical fatigue or collapse as symptoms, overwork as cause, or rest as cure be taken as roughly indicating those who were thinking of this "exhaustion syndrome," then, 42 per cent of those who described this syndrome classified it as mental illness, while 52 per cent of those who made no reference to

"exhaustion" regarded "nervous breakdowns" as mental illness. Similarly, those who described the tense-uncontrolled aspect of the syndrome, as indicated by mentioning any of the symptoms of loss of control, excessive weeping, tension or heightened irritability, were less likely to classify it as mental illness than those who described "nervous breakdowns" in other terms. And, once again, those who spoke in terms implying nerve damage--whether their reference was literally-meant or metaphorical--were also less likely to regard the resulting syndrome as mental illness. If these three leading elements of "nervous breakdowns" are combined, the proportion willing to classify "nervous breakdowns" as mental illness increased from 37 per cent of those whose depictions included the entire exhaustion--nerve damage--tense, uncontrolled sequence to 58 per cent of those who described "nervous breakdowns" without reference to any of these elements. (See Table 17.) The immediate influence of this imagery on judgments was sufficiently strong that, even where essentially similar syndromes had previously been offered as first impressions of mental illness or as impressions of non-psychotic mental illness, persons who repeated this description for "nervous breakdowns" were less likely to call the syndrome mental illness than were people who offered some other characterization.

These results point immediately in two directions. On the one hand, they suggest that consideration of the syndrome typified by "nervous breakdown" resulted in self-contradiction and shifting of the meaning of mental illness for most people. At the same time, however, they begin to illuminate something of the underlying logic to which people appealed in trying to decide what to call mental illness and which is, itself, a partial explanation of why there was so much inconsistency and confusion. In this instance, it is rather clear that attempts to distinguish "the physical" from "the

mental," combined with some easy assumptions about the relation between cause and effect and their relation to modes of classifying illness, contributed to confusion. It can, in fact, be shown that, for the most part, people were assuming either that physical symptoms are sufficient evidence of physical illness or that physical causes must necessarily produce physical illness. An orderly account of the kind of reasoning implicit in people's thinking about mental illness and the dilemmas in which it resulted must be postponed to a later chapter, however, where the evidence for the conclusions can be more systematically presented. Before that analysis can be undertaken, it is necessary to come to some interim conclusions about the meaning of mental illness and the consistency with which the term was used.

Total Impressions of Mental Illness

By the time people had finished talking of "nervous breakdowns," as the third step in this exploration of what meaning people gave mental illness, there were few left who had maintained a consistent formulation of mental illness. Thus, one-third of those who described "nervous breakdowns" in psychotic terms--some seven per cent of the entire population--had, nevertheless, been able to maintain simultaneously that they were not mental illness. And, of those who described "nervous breakdowns" in non-psychotic terms and had previously acknowledged the existence of non-psychotic mental illness, exactly half (31 per cent of all people) inconsistently excepted "nervous breakdowns" from the category. Conversely, close to a third (five per cent of the population) of those who had previously not accepted the inclusion of non-psychotic categories in mental illness described "nervous breakdowns" in non-psychotic terms, but called them mental illness. When these inconsistencies are added to those raised

by a consideration of "non-insane" mental illness, little remains by way of consistent viewpoint.

As shown in Table 18, at most 28 per cent held consistently to a view of mental illness which included non-psychotic syndromes and at the same time contained neither internal contradictions nor gross deviations from and inconsistency with the usual technical meaning of psychotic and non-psychotic. Another seven per cent of the American public consistently maintained an identification of mental illness with psychosis. For the rest, about three per cent had little or no conception of mental illness at all, while 62 per cent held views of mental illness which were confused, shifting and contradictory.

An attempt has been made, in Tables 1, 2, 3, 11 and 15, to give a composite view of what people said about mental illness by combining into a "total impression" spontaneous first impressions, depictions of "non-insane" mental illness and descriptions of "nervous breakdowns," whenever these were classified as mental illness. These figures must, however, be treated with caution, in the light of the great inconsistency that lies behind them. Thus, Table 15 shows that, over this set of questions, 75 per cent of the American public did, at least part of the time, actually include non-psychotic syndromes in what they called mental illness. Yet, it must not be overlooked that they were not always aware that these syndromes would be technically classified as non-psychotic and, more important, the large majority of them vacillated in their willingness to include the non-psychotic. Similarly of the 22 per cent who included only psychosis within mental illness, only a third were completely consistent in this usage.

Considering that this picture of wide-spread uncertainty, conflict and inconsistency as to the meaning of mental illness resulted from public

discussion of only three of the many questions which might have been posed, it is inevitable that not all of the difficulties of the average person in dealing with the concept of mental illness have been uncovered here. There is, therefore, every reason to conclude that there was neither general consensus nor individual clarity about the way the term, mental illness was defined and used.

(Revised)

PART II: THE MEANING OF MENTAL ILLNESS

CHAPTER 3

POPULAR PERCEPTIONS OF MENTAL ILLNESS

Introduction

Mental illness is not a term which has a precise, fixed, agreed-upon meaning, even in professional circles. The National Association for Mental Health, for example, divides the area of mental "ill-health" into mental illness (which includes only psychoses and severe psychoneuroses), other personality disturbances (which include mild psychoneuroses, psychopathies and a variety of personality and behavior disorders), and mental deficiency.[1] Many psychiatrists, on the other hand, would include all three of these categories under the heading of mental illness and might even add others.[2]

[1] The National Association for Mental Health, Inc. "Facts and Figures about Mental Illness and Other Personality Disturbances," April, 1952.

[2] See for example, R. H. Felix, M.D. and Morton Kramer, "Extent of the Problem of Mental Disorders," The Annals of the American Academy of Political and Social Science, March, 1953; American Psychiatric Association, Diagnostic and Statistical Manual, 1952.

These disagreements are, nevertheless, more apparent than real, for, however they are grouped, all of the general diagnostic categories subsumed under mental illness in its broadest usage are recognized by all professionals as disorders which require attention and which fall within the mental health field. Psychiatric diagreements over terminology and diagnosis have dealt not so much with setting these broad limits to the field as with problems of individual diagnosis, relatively

fine diagnostic distinctions and the borderline case. In fact, the term "mental illness" is not an important one within the mental health field, and little attention is given to the question of just what it includes. Since the general classes of disorders which concern the field are known and can be individually named, the tendency has been, instead, to refer to them collectively by some title which suggests their range and variety. Thus, the International List of Diseases and Causes of Death prepared by the World Health Organization now groups these disorders as "Mental, Psychoneurotic and Personality Disorders," and the American Medical Association's current Standard Nomenclature of Diseases and Operations refers to them as "Diseases of the Psycho-Biologic Unit."

In popular discourse, the term "mental illness" assumes importance, because it is the only way that people can refer, however imprecisely, to the range of phenomena which are regarded, professionally, as disorders of mental health. It is a remarkable and peculiar fact that there are no terms in common usage that can be used to refer to these disorders individually in a way that will be generally understood. Even if only the two most traditional categories of mental illness-psychosis and neurosis --are considered, the popular vocabulary has no words which unequivocably and unambiguously correspond to these concepts.

Popular speech does, of course, contain a number of colloquial terms--like "crazy," "nuts," "out of your mind," and, even, "insane"-- which are sometimes used as synonyms for psychosis, but these same expressions are so frequently heard in contexts where it is clear that their immediate intent is to express nothing more than transient disapproval of or disagreement with another person's conduct or ideas that it is not always possible to tell what is meant and what understood by their use. It is only when the operational criterion of actual or needed institutionalization is added to such epithets that they become relatively clearcut designations of psychosis, but, at the same time, they then apply to

a somewhat narrower range of disorder than that of the psychiatric category of psychosis. Since the course of a neurosis does not generally include a definite signalizing event like institutionalization, it is even more difficult to find ways of specifying it. Probably the most common popular approximation is the notion of "nervousness," but it is vaguely and diffusely applied to both a good deal more and a good deal less than is contained in the technical concept of neurosis. These difficulties in the way of communicating in the mental health field cannot presently be met by recourse to a more technical vocabulary. The imprecision and indefiniteness of reference of the everyday terms cannot possibly exceed either the general unfamiliarity of the public with such terms as neurosis and psychosis or the inexactness with which they are understood or employed by the minority who can recognize or pronounce them.

The ill-defined and diffuse qualities of popular conceptions of mental illness, the lack of general agreement about what mental illness includes and the absence of words which can be used to distinguish one way of delimiting mental illness from another--these are, to some extent, simply assertions that call for proof or disproof, and they anticipate, in rather dogmatic fashion, the empirical evidence of this study. Nevertheless, these conceptual and semantic difficulties must be mentioned at this time because they are not merely hypotheses which were confirmed by this research, but are, simultaneously, pre-existing conditions which made any exploration into popular views of mental illness singularly difficult.

The research difficulty was, simply, that ambiguity could not be directly avoided. When we talked with people about their ideas of mental illness, there was every likelihood that the term would mean different

things to different people, and there was no way to specify the term, mental illness, so it would mean the same thing to each person. Instead, the undefined term had to be employed with the recognition that people were not necessarily talking about the same thing, even though all of them were expressing their views of mental illness. In essence, we could only talk with people about mental illness when mental illness was left a term of undefined reference, but, so long as it was undefined, we could not meaningfully interpret what was said.

Since the study would be pointless under these conditions, an indirect approach that would eliminate ambiguity had to be found. The procedure adopted was to find out, in each person's own words, exactly what he meant by mental illness and, especially, how he would describe the symptoms of mental illness. The limits of inclusiveness of each person's usage were then tested explicitly, by asking directly whether his usage included or excluded a variety of syndromes, some of which were labelled and others of which were described rather than identified. From this account, each person's conception of mental illness could be roughly translated into the technical categories of mental illness that appeared to be included in his usage. By means of these approximate translations into terminology whose meaning can be kept relatively precise and unvarying from person to person, it is possible to specify the different ways in which different persons defined mental illness and the extent to which people adhered to internally self-consistent views of mental illness, even though their usage might differ from other people's.

Thereafter, the semantic difficulties resulting from the fact that mental illness does not have a common definition, could be avoided.

That is, any further statement about mental illness--its causes, treatment, prognosis, emotional connotations, etc.--was regarded as a statement applicable only to mental illness as conceived by the person making the statement and understandable only by reference to that individual conception. For example, if a person said that he was afraid of the mentally-ill, the knowledge that, for him, mental illness referred only to those psychotic syndromes in which violence is a prominent feature prevented the erroneous equating of this person with a person for whom mental illness included a variety of mild emotional disorders, but who was, nevertheless, fearful of the mentally-ill. In this instance, the seeming similarity of the attitude of fear of the mentally-ill concealed, because of a difference in terminology, a possible large difference in attitudes toward neurotics. In much the same way, a seeming difference in attitude could turn out to be a mere difference in terminology which concealed agreement in substance.

Given the necessity of this indirect approach, the ability to determine what people meant by mental illness is a most crucial phase of the research. Accordingly, this chapter is devoted to presenting, in some detail, the kinds of definitional and descriptive discussions of mental illness contained in the interviews and the way in which these were interpreted to obtain relatively clear-cut designations of variations in individual usage of the term.

First Impressions of Mental Illness

The concept of "mental illness" was, for most people, ill-defined and not at all clearly understood. They had some difficulty verbalizing about it at all and spoke rather haltingly in their attempts to formulate their ideas. In answer to the initial question,

> When you hear someone say that a person is "mentally-ill," what does that mean to you?
> (PROBES: How would you describe a person who is mentally-ill? What do you think a mentally-ill person is like? What does a person like this do that tells you he is mentally-ill? How does a person like this act?),

people usually began by replacing mental illness with an equivalent phrase like "mental sickness" or "sick in the mind" or by using labels or summary characterizations that were so vague or so general as to be meaningless. It usually required repeated questioning and exploration to obtain answers formulated in terms concrete enough to convey some sense of the person's conception of mental illness. Here for example, are a few typical answers:[3]

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[3]Whenever answers are quoted in this report, they are a strictly random selection from among all answers in that category. Any other method of selecting illustrative quotations carries with it the danger that only the more striking answers or only those most in line with the interpretation being advanced will be cited. The intent here is always to convey, without bias, the flavor of the original data, although it must be recognized that their range and variety cannot be fully captured in the limited number of illustrations that can be included.

> It means that they are mentally sick. (P.)
> He's abnormal in his behavior. (C.)
> He says peculiar things and acts noticeably different from other people. (C.)
> Being unusually moody, being worried all the time over real or imaginary troubles, always thinking there's something wrong with his health.[4]

---

[4]The parenthetical symbols represent questions asked by the interviewer after the original question. "P." indicates that one of the probes suggested in the question was used--for instance, "How does a person like this act?"--or that additional description was requested--e.g., "How else does he act?" "C." indicates that the interviewer's question asked for clarification of what had just been said--e.g., "Abnormal? How do you mean?" or "Could you give me an example of that?".

Nuts in the head. (P.) It's a mental derangement where his actions are below normal and they have no control of themselves.

Well, the man is not doing things the way he should; he's unbalanced. (P.) Well, he would be irritable for little or no reason. (P.) He'd have a bad memory, forget things easily. (P.) He might be spiteful--he might show signs of bad habits. (C.) Spitting on the floor of his own house. I knew someone who did that. (C.) He'd spit on his own living-room floor, not caring at all. (P.) He's the only one I know. (P.) I think that they'd hurt others and not care at all. (C.) Insult them. (P.) Not that I know.

Insanity. (P.) Imagination. (C.) They imagine they have money hidden somewhere. (P.) They talk about it. (P.) They think people are after them.

Someone who has a sick mind. (P.) By talking strange and acting strange. (C.) By doing things that seem out of line with normal behavior. (C.) Reacting to a thing that is of little consequence and he will make a big thing of it, and talking all the time about it so he wears everyone down with it and you want to get away from him.

They are disturbed in their minds. (P.) Not able to cope with life. (C.) Where they are so disturbed they can't carry on like the rest of us. They can't see things as they are.

Most affected, I imagine, in the brains, ain't it? I don't know. (P.) He just don't think right or do normal things. (P.) He's just nervous, I imagine, and can't think straight. Some of them when they're mentally sick want to fight, and some of them don't know what they're saying. They'll just say anything.

They are unable to carry on a normal life. (P.) They generally are incoherent in their talk and thoughts. (P.) They have dilated eyeballs.

A great depression of spirits. (P.) Easy tasks become difficult. (P.) A feeling of fear without reason. You lose all zest for living, no pleasure in anything.

Not all the time, mentally /ill/, just nervous--some worse than others. I'm a nervous type myself. It's from change of life or, sometimes aggravation. (P.) Sometimes they say things they shouldn't. They just go around and don't bother anyone. They keep on talking. They could be cured. (P.) There are different kinds of mental sickness. (P.) They go around and don't bother anyone. (P.) Sometimes they won't talk to people, lock themselves in, want to hit someone.

> A nervous, jittery person. (P.) He acts like us; he'd have to be very intimate to really know what's the matter. (P.) They're not crazy, so they act like us; only a doctor could really tell something was bothering them.

In all, close to half the answers (47 per cent) contained "rough-and-ready" references to diagnostic categories like the "nuts in the head" and the "nervous type" in the preceding quotations. Just over half (54 per cent) made vague summary characterizations, as exemplified by the undefined use of words like "abnormal," "peculiar," "different," and "unbalanced" in these illustrations. Sooner or later, however, the large majority (81 per cent) were able to speak, in more concrete terms, of what they meant by mental illness. In terms of completeness of answer, then:

4%...said only that they could not describe mental illness.

15%...spoke only in terms of popular diagnostic equivalents or summary characterizations, or both.

63%...began in these general terms, but progressed to the particular.

18%...spoke in concrete terms throughout.

While these results do indicate the halting and tentative way in which most people spoke of mental illness, they do not adequately convey the content that was assigned to it. In order to get a fuller sense of just what people were talking about, the concrete elements in their discussions must be examined in some detail. Their variety and diversity is so great, however, that a kaleidoscopic impression would result, if they were introduced immediately. Instead, the data will be easier to follow if we anticipate by beginning with the final conclusions and use these to organize the concrete materials.

When people's initial descriptions of mental illness are classified by a process of deciding what diagnostic category or categories the descriptions seemed to be referring to,[5] it turns out that, for at least half the adults of the United States, the spontaneous image evoked by the phrase, mental illness, was a picture of psychosis. As shown in Table 1,[6] exactly 50 per cent were classified as referring only to psychosis in their discussion of mental illness, 12 per cent described both psychotic and non-psychotic syndromes, and 33 per cent appeared to refer only to non-psychotic syndromes.[7] Beyond these major groupings, there was an occasional tendency

[5] The process of imputation employed was actually quite complex. Initial judgments were made by coders with training in clinical, abnormal and social psychology and familiarity with psychiatric concepts, after which a statistical analysis was used to secure a better approximation. The technical details of the procedure are explained in Appendix A, Note 3. It should be emphasized here, however, that the procedure--like all procedures used in this research--was deliberately designed to yield conservative results. All analyses and interpretations always followed the basic assumption that the respondent's views were to be regarded as accurate and reasonable--as corresponding with technical usage and outlook and/or as consistent within themselves, if they could possibly be so viewed. The effect of this approach is, of course, to place the burden of proof on those who believed that people were generally misinformed and confused about mental illness. As a result, the bias in our conclusions, if there is any, is in a direction opposed to our basic hypotheses about what we would find to be the case and not in the direction of finding confirmation for what we believed, a priori. Our conclusions, therefore, extreme though they may seem, if anything minimize rather than exaggerate the extensiveness of ideas about mental illness that are at variance with technical usage.

[6] All tables are presented in Appendix B.

[7] In the next section of this chapter, it will be shown that this spontaneous identification of mental illness with psychosis did not represent the complete picture of mental illness for most of the people who thought of psychosis initially. Where there was no apparent mention of the inclusion of psychotic syndromes within mental illness, no comparable attempt was made to test the limits of the concept of mental illness. It is our impression, however, that the bulk of persons classified as referring only to non-psychotic syndromes would also have included psychosis under mental illness, if this point had been raised, as the opposite one was raised for those who made no reference to non-psychotic syndromes. There were a few people who said explicitly that they regarded the term, mental illness, as a contrast term to psychosis or insanity, used to refer to mental disorders short of psychosis; that is, "Some people are crazy, but others are only mentally-ill." This point of view was, however, so infrequently expressed that no attempt was made to determine exactly how often it occurred.

to include within mental illness a group of syndromes that have in common high social visibility; that is, about three per cent appeared to be describing either exaggeratedly eccentric types represented by misers, recluses and cultists or social deviants like criminals, alcoholics, drug addicts and homosexuals. Still less frequently, the concept of mental illness appeared to contain mental deficiencies and a variety of illnesses and reactions not generally regarded as mental illness--epilepsy, spastic paralysis, momentary justifiable fear or anger, and the like. About one per cent described only mental deficiency or those syndromes not usually classified as mental illness, while four per cent were not able to formulate any description of mental illness. Since these figures are derived by procedures deliberately designed to yield a conservative estimate, it is likely that the tendency to identify mental illness with psychosis was even more widespread than these data suggest.

These, then, were the broad categories that underlay people's first, spontaneous impressions of mental illness. Since each of the categories contains a variety of syndromes, however, the popular image of mental illness is summarized rather than described by them. For a more concrete depiction of public conceptions of mental illness, we must turn again to the three elements of description which were isolated from people's comments: diagnostic labels, summary characterizations and specific descriptions of symptoms and manifestations.

As mentioned earlier, just under half the public made use of diagnostic terms or popular equivalents for them. The most frequently used diagnostic category was made up of the previously-mentioned terms suggestive of psychosis. Close to one-fourth of all persons--just about half of those who referred to diagnostic categories at all--made references

suggesting psychosis in these terms, while references to nerves, nervousness or nervous disorders followed close behind. Much less frequently, there were mentions of non-psychotic disorders generally--usually in the oblique form of "not all of them are crazy" or "some are out of their minds, but some are not," of nervous breakdowns, and of neuroses or emotional and personality disorders. (See Table 2 for more exact detail.)

As might be expected, the popular terms, like "crazy," "out of his mind," etc., generally were used to refer to psychoses, while "nerves" usually referred to the non-psychotic. However, with the exception of the technical term, "neurosis," the popular non-psychotic labels were rather frequently employed to refer to psychotic types of syndromes. Thus, of the people who described psychosis and employed some label for their description, roughly three out of five used the popular words for psychosis, while two out of five referred to psychoses with the presumably non-psychotic terms of "nervous disorders," "nervous breakdowns," and non-psychotic mental illness, generally. In contrast, non-psychotic syndromes were seldom linked to psychotic labels: of the people who described non-psychotic syndromes and used labels for them, only one in sixteen employed psychotic terms. (See Table 3.)

Essentially, summary characterizations of mental illness were of two types, the one stressing "mental" and the other, "illness." (See Table 4.) Where the emphasis was on "mental," as it was for 58 per cent

of those who spoke in summary terms, the mentally-ill were regarded as deviating from the norms of rationality, consistency and control in thinking and action. The degree of departure from these norms that was attributed to the mentally-ill varied all the way from the legal concept of incompetence to the feeling that the mentally-ill were undependable, changeable or impulsive:

> They are out of their mind and don't know what they are doing or saying.
>
> They just don't have their right mind and do all kinds of things that don't make good sense.
>
> They might be confused and do erratic things.
>
> They are irresponsible--you couldn't depend on them to do anything or couldn't be sure they would carry it out.
>
> They become no good to themselves or anyone else. They're just not "at" themselves--they're off, mentally not responsible.
>
> They do things that people don't do normally. They are not reliable.
>
> You never know from one minute to the next what they are going to do.
>
> They are mentally unbalanced, abnormal. (C.) They are childish.
>
> They can't always control their thoughts and actions.
>
> He would be disorderly in conduct.
>
> They seem to have very little control over their emotions.
>
> They are either way up or way down.
>
> I'd say, very emotional and they do things to excess.

Where the emphasis was on "illness," the mentally-ill were characterized as generally disordered or deviant, without reference to any particular norms that they were perceived to violate. Over half the time, the standard of normalcy was left unspecified; for the rest, it was usually equated

with the social standard of "the way other people act" or, occasionally, with the intra-individual standard of "the way he used to act." For example,

> They just act a little odd.
>
> They are just peculiar.
>
> Some are kind of queer.
>
> He says and does crazy things.
>
> It means they are unbalanced.
>
> He does things a right person wouldn't do--silly things.
>
> He isn't suited to get along with the rest of us normals.
>
> They act more or less not like a normal person.
>
> They act strange, do things that seem out of line with normal behavior.
>
> They do things that under normal circumstances they would not do. You notice that they are changed from their previous conduct.

These summary ways of characterizing the mentally-ill are so general that, with the exception of the notion of legal incompetence, they might equally well be applied to the mildest instance of personality disorder or to the most severe instance of psychosis. Nevertheless the cumulative impact of their invariable stress on deviancy tends to create the impression that the people who used them had in mind more extreme deviation than their statements, taken literally, implied. This impression is confirmed, to a degree, by the data presented in Table 5, which indicate that two-thirds of those describing psychotic syndromes made use of summary characterizations, while slightly lessthan half of those describing non-psychotic syndromes did. Once an allowance is made for this differential use of summary characterizations, those describing psychoses tended to characterize them in terms of incompetency, while those describing non-psychotic forms of mental illness used lesser degrees of emotional deviancy and, particularly, lack of control and instability, relatively more frequently.

Specific descriptions of mental illness, as might be expected, were

the details of which are shown in Table 6.[8] The major lines of emphasis were:

[8]The classification of symptoms of mental illness employed here was deliberately designed to impose as little conceptualization on the way people talked as is consistent with the necessity of grouping into categories, on the basis of their similarity, answers which were, in some respects, unique. Like all systems of classification, it contains an element of arbitrariness, and alternate ways of grouping the basic categories into major classes are not only conceivable but may even strike the reader as more reasonable or more useful. The main advantage of this mode of classification is just that these alternatives are available; the source materials are not inflexibly constrained to any one way of conceptualizing them. The preservation of so much of the concrete detail makes it possible to combine categories along the lines of any method of conceptualization one may wish to apply, and the relation of a particular conceptualization to the empirical evidence is fully exhibited. In contrast, an initial classification in terms of a conceptual scheme at a level of abstractness remote from the plane at which popular discourse took place is much more rigid; once the concrete materials are so ordered, they cannot conveniently be translated into a different ordering system, and only the original classifier can know precisely how adequately the conceptual scheme fits the concrete depictions it is intended to organize. For an example of another mode of classifying these data, see Appendix A, Note 3.

1. Disordered emotional tone. Slightly over a third of the public described symptoms which centered around the individual's subjective state or mood. The stress here was on the familiar pattern of irritability, sensitivity, anxiety and depression, with less frequent references to withdrawn, apathetic and indifferent attitudes. Illustratively:

> That's only a nervous ailment. (P.) He worries--that's all it is.
>
> It means a person is worried. (P.) They get upset so easily. (P.) Well, you know, they are nervous.
>
> They seem to be extremely upset over things. (P.) I really don't know. (P.) They cry easily and get furious over nothing.
>
> They are offended easily and fly off the handle.
>
> They're fussy, cranky and irritable.
>
> Nervous, high-strung, erratic people are mentally-ill. (P.) Sort of impulsive, sort of flighty. (P.) I don't know. (P.) I think they're depressed.
>
> They might be quiet and melancholy.

2. Intellectual impairment. About as frequent as reference to emotional disturbance were comments on impaired thought processes.[9]

---

[9] For the sake of clarity, symptoms attributed to mental deficiency and to conditions not generally classifiable as mental illness were disregarded. These intellectual types of symptoms and all other symptoms described were, therefore, attributed to forms of mental disorder other than mental deficiency.

These tended to assume a more extreme character than did the references to mood, however. Foremost in this category, and the most frequently mentioned symptom of any class, were references to the incoherence, irrationality and incomprehensibility of the talk and conversation of the mentally-ill. This "inappropriate talk," together with lack of comprehension and major disorders of memory and orientation, dominated over half the descriptions of intellectual impairment. In a less frequent version, the intellectual impairment was perceived as much more moderate--a kind of impaired performance or efficiency growing out of brooding, preoccupation, or obsession and taking the form of absentmindedness, forgetfulness, or a decreased ability to concentrate. For example:

> Well, it seems their mind is not right. (P.) They don't recognize anybody and don't seem to know what they are doing--no presence of mind.
>
> They talk irrationally and don't remember things.
>
> Their mind is not right--not active. (P.) By his everyday actions. He's not active, doesn't perform his daily duty. (P.) They can't keep on the subject --jump from one thing to another.
>
> This dentist would neglect his business and he would talk out-of-the-way.
>
> Their conversations are not quite normal. They talk incoherently.
>
> You would notice their being absent of speech, being nervous, forgetful and childish. He dwells on one subject, thinks just one way.

> They are not adjusted to combat every-day life. They are nervous and probably wool-gatherers.

3. Distortion of reality. About a quarter of the public described degrees of misinterpretation of themselves and of the world around them as characteristic of the mentally-ill. These ranged from delusions, hallucinations and a frank break with reality to more frequent references to attitudes of distrust and suspicion, hypochondriacal tendencies and more generalized readiness to perceive events subjectively and reject or ignore inacceptable facts. For instance:

> I would think that they thought they were insane. (P.) They imagine things that are not true. (C.) Such as thinking people will kill you. (P.) They might hear voices.

> He's queer. (C.) Suspicious of most people, always looking for trouble and imagines pains and aches.

> Lots of times they think they're sick and then they get to worrying, and this really does make them sick.

> They have an ill-adjusted life. (C.) Either they haven't grown up or they can't face reality.

> They are the last ones to admit it. They don't recognize it in themselves.

4. Deviant external appearance. About a fifth of the public made references to the external appearance of the person, roughly half of these comments being descriptions of tension, restlessness and inability to relax together with accompanying tremors and tics. The other descriptions in this category took the more extreme form of stuporous, trance-like states, postural oddities, a peculiar look in the eye, and the like:

> It's a nervous condition that makes them just go all to pieces--nervous, shaky, may shake the head or some other part of the body.

> Their actions are nervous and jittery; some pace the floor.

> The ones that go crazy, they stare. (P.) They just stare and are kind of numb.

I imagine they don't walk or talk like everyone else. They have a queer look, a dazed look out of their eyes. (P.) Most of them let themselves go, won't shave or clean up.

5. Violent acts. About one person in seven made reference to acts of violence--self-destruction, homicide and the like:

They are nervous. (P.) They might try to commit suicide. (P.) They might kill other people.

Sometimes they get awful violent and try to hurt somebody.

They could harm themselves--hitting themselves against walls--or cause fires.

6. Violent, extreme expression. One person in ten described uncontrolled, extreme or violent expression of emotions as characteristic of the mentally-ill, referring chiefly to excessive weeping, tantrum-like rages, and meaningless laughter:

They laugh or cry often, want to be alone a lot, hide from people, and scream.

Sometimes they cry a lot and walk the floor, and it seems like they want to scream and do sometimes.

7. Disordered self-image, character traits. One person in ten attributed to the mentally-ill a variety of personality characteristics which had in common a disordered conception of self. Thus, the mentally-ill might be described as chronically dissatisfied and complaining, as egocentric and overly-demanding, as self-pitying and martyred, as insecure, as self-righteous, or as overly-submissive:

The only one I knew carried on and bothered everyone to do things. (C.) By carrying on I mean she complained loud and long and wanted to be waited on.

They let their emotions get the best of them. (C.) They expect a lot of sympathy and they worry. (P.) It's mental illness when he starts feeling sorry for himself and trying to get sympathy.

8. Health impairment. One person in ten described physical symptoms like chronic fatigue, loss of appetite, insomnia, and so on as accompanying mental illness:

> They are sick all over, think they are going to die, can't sleep and nervous.

> Some of them are tired all the time. They can't sleep, can't work. They have indigestion or a nervous stomach.

9. Speech mannerisms, disorders. Still less frequently, people described speech habits like talking to one's self, refusal to speak, excessive or too little talking, rapid or retarded speech rates:

> He does curious things. (C.) Well he might talk to himself or might laugh a lot about things that ain't funny.

> Well, I hear they act sort of funny. (C.) So quiet, and sit and mope around, won't talk to you or else talk your head off.

10. Exceptional, unusual behavior. About one person in twenty gave illustrations of behavior that struck them as deviant. These ranged from the bizarre, almost uninterpretable acts of psychotics to instances of violation of cultural standards:

> Some of them won't leave their clothes on or they want to wear only certain things.

> Just pile stuff around like my wife does. She's not reasonable; she saves things that are just useless and piles them up in piles.

11. Anti-social habits. The final and least frequently mentioned group of symptoms was that involving violations of moral standards--alcoholism, drug addiction, criminality, delinquency and sexual deviancy:

> It's not necessarily insanity. Alcoholism is mental illness. (C.) He's looking for escape and may turn to drink or dope or may just give up and allow himself to become mentally-ill.

In terms of specific symptomatologies, the typical popular description of psychosis included references to intellectual impairment.[10] Of those who offered specific descriptions of psychosis, just over half made comments classifiable as intellectual impairment, and 29 per cent expressed it in terms of the single category of "inappropriate, incoherent, irrational talk." Acts of violence were the second most frequent manifestation in the psychotic syndrome popularly depicted and were included in the same proportion as were references to irrationality in speech. Beyond these two dominant symptoms, descriptions of psychosis tended to scatter, with no other single specific category mentioned by as many as ten per cent of the public. (Details are presented in Table 7.)

The non-psychotic category, on the other hand, was dominated by references to deviant emotional tone: about two-thirds of those who described the category used some such descriptions with symptoms like irritability, anxiety, depression and hostility to the forefront. Accompanying these mood symptoms and about as frequent, were such complementary symptoms as tension, distorted self-images, and preoccupation.

The Status of Non-Psychotic Mental Illness

While the preceding section has indicated that, for a majority of the public, mental illness tended to call forth an image of psychosis, it

[10] This present description of the way broad diagnostic categories were popularly depicted contains an element of circularity, since, in the majority of cases, these same descriptions were used as the basis for determining what diagnostic categories people had in mind, as explained in Appendix A, Note 3. Because the method used was designed to avoid overestimating the extent to which mental illness was equated with psychosis, it may be that the rather extreme symptomatology apparently associated with psychosis in popular thinking is exaggerated by a tendency to classify borderline instances as nonpsychotic.

should not be assumed that this was, for the most part, a consciously-held view of mental illness. On the contrary, when the question of the identity of mental illness with psychosis was specifically raised, the overwhelming majority asserted that mental illness included more than psychosis:

> Would you say that everyone who has a mental illness is out of his mind...insane, or not?[11]
>
> Insane 10%
>
> Not insane 83
>
> Undecided, don't know . . 7
>
> 100%

---

[11] This highly colloquial terminology was used throughout the interview to refer to psychosis, as these were the phrases people were most likely to understand.

Even those whose spontaneous impression of mental illness included only psychosis, usually gave formal assent to the inclusion of more than psychosis within mental illness: 75 per cent of them accepted this broader view, while 16 per cent indicated that their view of mental illness was limited to psychosis and nine per cent were not sure what they thought.

As described by those who believed that mental illness included more than "insanity," the illness of the "non-insane" mentally-ill was most frequently thought of as "nerves" or "nervousness," with less frequent reference to "nervous breakdowns" and emotional disorders. Summary characterizations were used less often than they had been in describing mental illness in general, but where they were used, there was a shift away from viewing the mentally-ill as legally incompetent toward such categorizations as uncontrolled and unstable. In terms of more specific description of symptomatology, the "non-insane" most typically emerged as tense, irritable,

anxious, depressed individuals, who were preoccupied with their problems and, consequently, forgetful and absentminded or hostile and difficult to get along with. There was, of course, a great deal of description that would not fit so well into the rather consistent neurotic syndrome just outlined, but this syndrome was the only one which emerged with sufficient frequency to constitute some common core of meaning in diverse views of "non-insane" mental illness. To put some spark of life into this rather abstract summary, here are a few representative answers to the question, "What is the matter with the ones who aren't insane, then? (PROBES: How would you describe them--the ones who aren't insane? What are they like? How do they act?)"

> Nervousness. (C.) They might be sick physically; they would never be relaxed.
>
> I would say they're not insane or completely out of their mind, but I would say they can't seem to grasp the situation or meet it or sit down and reason out a problem. (P.) The ones that aren't insane, I would say are those people who had adjusted themselves and had been able to cope with any problem that has come up and who had been able to make a decent living and have no worry as to income that they have. (P.) To my way of thinking, they are easily aroused at the least provocation and become very violent. (P.) They're unusually sullen, not very talkative. (P.) Usually when asked a question their retorts are usually sharp and a "none-of-your-business" attitude, insulting.
>
> There are degrees and degrees. Some can carry on a very normal existence, they are not out of their mind continuously and they can live with the rest of the world. (P.) The insane should be in some institution.
>
> I think that something is bothering them that they have to clear up. (P.) They act nervous and upset.
>
> It's usually nerves. (P.) It could be a nervous breakdown. I never had much experience with it. (P.) I suppose they have wakeful nights, have loss of appetite, feel fatigued. (P.) They are tired out and depressed.

> Well, I'd say they are upset. (P.) Sometimes they are forgetful. (P.) They make other people miserable; they seem perfectly all right at times, then they get upset. (C.) I really don't know, I don't know anything definite to say.
>
> He has the kind of blood that needs cleansing. (P.) They can get relief from mental illness by confessing and helping themselves.

Taken as a whole, the descriptions of "non-insane" mental illness, which can be seen in more detail in Tables 2, 4 and 6, were essentially/ the same as those which had been given for mental illness generally by the sub-group whose first descriptive impressions referred to non-psychotic syndromes. If Table 3 is compared with Table 4, it is apparent that summary characterizations spontaneously identified with non-psychotic syndromes were about the same as those given when a description of non-psychotic mental illness was explicitly asked for, once an allowance is made for the differential frequency with which this type of description was used at all in the two instances. Similarly, Table 5 in comparison with Table 6 indicates that specific symptoms of each type were ascribed to non-psychotic mental illness with the same relative frequency in spontaneous and directed descriptions.

The implications of this similarity are two-fold. First, it serves to underline the fact that the view of non-psychotic mental illness previously derived from the first impressions of the minority who spontaneously said that they meant to refer to non-psychotic syndromes was quite representative of the image of non-psychotic mental illness held by the majority of the public who had not made their inclusion of non-psychotic syndromes explicit, but who, when reminded, agreed to their inclusion. In other words, the contrasting popular images of psychosis and non-psychotic mental illness

that were derived from first impressions are not at all altered by a consideration of the manner in which the majority of the public thereafter tended to describe non-psychotic mental illness. By the same token, however, this general agreement on what entered into non-psychotic mental illness reinforces the conclusion that mental illness, when used as a term of general reference, tended to evoke a psychotic image. That is, when descriptions of first impressions of mental illness and of "non-insane" mental illness are compared, all of the differences are in the same direction as the differences in description of psychotic and non-psychotic syndromes. It is noteworthy in this connection that, among the vast majority who agreed that mental illness included more than "insanity," 45 per cent had described only psychosis in their first, spontaneous impressions of mental illness, while 50 per cent had included essentially non-psychotic description, so that the initial image of mental illness--even for those whose views of mental illness were broader than this--was, about half the time, psychosis.

This consistency in views of non-psychotic mental illness also implies that people sometimes included under the heading of "non-insane" mental illness essentially psychotic syndromes, just as they sometimes referred to psychosis by presumably non-psychotic terms. In addition to the 10 per cent who explicitly stated their limiting of mental illness to psychosis, there were some 13 per cent who, in practice, described only psychosis and two per cent who included psychosis as well as non-psychotic syndromes.[12] At the other extreme there were seven per cent who did not

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[12] These estimates of syndromes actually included within non-psychotic mental illness were arrived at through analysis of coders' ratings and symptomatology, using the same procedure which is fully described in Appendix A, Note 3. All of the qualifications and limitations indicated there apply equally here.

know whether they would include more than psychosis as mental illness, five per cent who agreed that mental illness should include more, but had no idea of what else it included and five per cent who could formulate non-psychotic mental illness only in terms of mental deficiency or of syndromes that would not generally be regarded as mental illness. In the final analysis, then, no more than three-fifths of the public (58 per cent) actually held a view of non-psychotic mental illness which approximated technical usage, and, given the procedures used, this figure must be regarded as a maximum estimate of the extent of public knowledge.

This conclusion is complicated by the use of the term, "insane," for it is possible to follow a legal usage whereby "insanity" applies only to the criminally or violently psychotic or to the legally incompetent, while all other psychotics are, by definition, not "insane." In point of fact, many of the people who did include descriptions of psychosis in their discussions of mental illness were, implicitly or explicitly, adhering to some such usage. Thus, of those describing psychosis under the heading of "non-insane" mental illness, only 16 per cent included references to the category of violent actions, while 29 per cent of those who described psychosis as their first impressions of mental illness made comparable references to violence. To put it another way, in the raters' judgment, 39 per cent of those who actually referred to psychosis under the heading of "non-insane" mental illness were describing non-violent psychoses--syndromes like senile psychosis, quiet, withdrawn catatonic states and the like, while 10 per cent referred only to the kinds of psychoses in which violence is a central feature, leaving 51 per cent who appeared to refer to psychoses generally or without regard to the violent-nonviolent dimension. In contrast, 79 per cent of the references to psychoses in first impressions of mental illness were in these general terms,

while 15 per cent referred to violent psychoses and six per cent to non-violent psychoses. Indeed, some 10 per cent of those who described psychoses under the heading of non-psychotic mental illness volunteered the statement that the presence or absence of violent behavior was the essential distinguishing criterion between the "insane" and the "non-insane" mentally-ill.

Nevertheless, the tendency to confound the psychotic with the non-psychotic was not, to any appreciable extent, a result determined simply by our having used the term, "non-insane"—whose literal, legal meaning is not identical with non-psychotic--as though it were equivalent. In the first place, the general level of public understanding of mental illness--as the discussion up to now has begun to indicate--was not such as to make it likely that any appreciable segment of the public was aware of and used in their thinking about mental illness a nuance like the difference between psychosis and insanity. More directly, however, as the data in Table 2 suggest, the tendency to perceive only psychotic syndromes as mental illness even when presumably talking about non-psychotic mental illness operated to about the same extent when the ambiguity created by using the term, "non-insane" was not present. That is, people who labelled their first impressions of mental illness as non-psychotic, by the use of such terms as "nerves," "nervousness," or "nervous breakdown," applied these terms to syndromes which were actually essentially psychotic with exactly the same frequency as "non-insane" mental illness turned out, upon closer inspection, to be psychosis: in either instance, 17 per cent of those who described the syndromes they had in mind were actually describing only psychoses while 73 per cent described non-psychotic syndromes.

What is apparent at this point is that, at best, only a bare majority of the American public used the term, mental illness, in a way which can be

regarded as roughly approximating its meaning and use in professional circles. That is, as an outside estimate, 58 per cent of the public explicitly acknowledged that mental illness included more than psychosis and, at the same time, had an image of non-psychotic mental illness which was consistent with what would technically be viewed as non-psychotic. The rest of the public divided between a small group who consistently adhered to a restriction of mental illness to psychosis only (about eight per cent) and a large group--34 per cent--whose views of mental illness already showed internal contradiction and confusion. Thus, there were at least nine per cent who, in practice, perceived and described only psychotic syndromes, even though they labelled and thought of them as non-psychotic. About four per cent described psychotic syndromes and weren't sure whether or not mental illness included anything else. Conversely, some four per cent thought that mental illness applied only to psychosis or weren't sure just what mental illness should include, despite the fact that they had described essentially non-psychotic syndromes. Or, again, some 10 per cent either could not describe non-psychotic mental illness or thought only of mental deficiency or of a variety of neurological disorders, even though some of them had described non-psychotic mental disorders, apparently without realizing they were doing so, in the first impressions of mental illness they gave. The complete interrelations of the three relevant questions--first impressions of mental illness, whether or not mental illness includes more than "insanity" and, where applicable, descriptions of "non-insane" mental illness are shown in Table 38, but it should be pointed out that this is not a final index of the extent of misunderstanding, confusion and inconsistency in popular use of the term, mental illness. On the contrary, it is simply intended to indicate that conceptions of mental illness began to fluctuate as

soon as more than one approach to the subject was made. As we shall see, continued exploration of the popular meaning of mental illness constantly expanded the amount and kinds of public misconception and confusion.

The Nature of "Nervous Breakdowns"

A somewhat different approach to the popular image of mental illness was made by specifically introducing into the discussion a term which has a good deal of currency--the "nervous breakdown." While it has been shown that the "nervous breakdown" was not actually one of the more frequently-used spontaneous terms of lay reference to mental illness, it was, nevertheless, widely recognized when mentioned, with some 95 per cent of the public able to offer some kind of description of it. Significantly, only one person in a hundred characterized the term as being too imprecise, ill-defined and non-technical to have any agreed-upon meaning.

In popular usage, a "nervous breakdown" was, generally, a term for a rather specific and acute syndrome. To the extent that its causes were discussed--and a surprisingly-large number (44 per cent) volunteered comments about its causes, a "nervous breakdown" resulted from overwork or from the pressures and strains created by such realistic life problems as economic difficulties and family frictions or from some combination of these two circumstances. The dominance of this point of view is indicated by the fact that, of those mentioning causes, 56 per cent referred to overwork, and 42 per cent, to realistic environmental difficulties; while the next most frequent causal category--that of physical causes other than overwork--was mentioned by only 16 per cent. (See Table .) This view of "nervous breakdowns" was frequently reinforced by imagery suggesting actual physical damage to or organic malfunctioning of the nervous system. Just about one

person in five (22 per cent) spoke of the nerves "becoming fatigued," "breaking down," "going to pieces," "shattering," "collapsing," etc. as the presumed mechanism by which the causal strains produced the ultimate symptoms. These strains, then, produced a condition of fatigue or a kind of weakening of self-control in which the person became extremely tense and unable to relax, quite irritable and easily upset, and given to unprovoked or excessive weeping, and the whole syndrome frequently developed to the point where the person collapsed and required a period of bed rest. (See Tables 4 and 6.) While comments about treatment were infrequent--only nine per cent volunteered methods of treating a "nervous breakdown," 75 per cent of these volunteered treatments consisted of rest, pure and simple, so that, while there was often an image of an acute breakdown, it tended to be viewed as a temporary episode that would subside once a person got enough rest to recover his strength or courage to face the many problems of life. The flavor of this popular view of "nervous breakdowns" can be seen in a few representative depictions:[13]

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[13]The question asked was, "As far as you know, what is a nervous breakdown? (PROBES: How would you describe it? What is it like? What happens to a person who has one? How does he act?)"

> Your nerves have gone to pieces. They can't function because they have been overdone.
>
> Some nervous breakdowns cause different ailments of the body. I don't think it always affects the mind completely. (P.) They can't sleep and can't rest. (P.) I think it can affect your heart and also the stomach--I've heard people say they had a nervous stomach. It can also cause you to have a rash on your body, a nervous rash--people are scratching.
>
> A person is overworked. (P.) A bad heart can cause it. (P.) Makes you nervous--your heart goes fast and it scares you and when you try to sleep your heart jumps.

> Just when you get all frustrated over the conditions of life and throw themselves down on the bed and can't carry on the battle. Then, the more you think on those things, the worse you get.
>
> I don't know, I've never known anyone who has had a nervous breakdown. (P.) Their nerves are just physically shot. (P.) No, their nerves are just shot completely--nervous exhaustion. (P.) They're so completely run-down that, whatever this condition was that brought it on, they just collapse completely. (C.) Mentally, they break down. It's something that has been bothering them; it grows and grows and they just snap. (C.) Their mind snaps; they need complete rest.
>
> Lots of things can cause that. Usually, it is a run-down condition. I would say more nervous breakdowns are caused from it. Small children have nervous breakdowns and it is caused from a run-down condition. (P.) Usually, they are sick or complain of being sick and are not able to go and do as they should.
>
> It's a person overworried. (P.) It's not the work it's the accumulation of too much worry with the work he has done. (P.) It's caused from improperly eating. (P.) He seems afraid or jittery, also sleepy all the time--he'd just rather lay down.

Although it is apparent that there was much less diversity and heterogeneity in the kinds of behavior included under the heading of "nervous breakdown" than was the case with mental illness, generally, or even with non-psychotic mental illness, it should not be assumed that there was public unanimity in using the term "nervous breakdown" to refer to the syndrome just described. In terms of our final rating of what was actually being described, "nervous breakdowns" emerged as an essentially non-psychotic syndrome for 72 per cent of the American public and slightly over half of this group appeared to be describing a syndrome in which physical malaise, fatigue or collapse was a central feature. At least 18 per cent, however, used the term to refer to the acute onset or recurrence of a psychosis, while two per cent described both psychotic and non-psychotic syndromes in discussing nervous breakdowns, three per cent described only mental deficiency or syndromes other than mental illness

and five per cent were not sufficiently familiar with the term to offer a description. (See Table 1.)

Despite their almost exclusive description of "nervous breakdowns" in terms that a person with technical knowledge would not hesitate to classify as mental illness, less than half of the public were willing to classify a "nervous breakdown" as mental illness:

"Would you say that a nervous breakdown is a mental illness or not?"

Is	48%
Is not	36
Undecided, don't know	16
	100%

And, oddly enough, people who explicitly assented to the inclusion of non-psychotic syndromes within mental illness were not very much more likely to regard a "nervous breakdown" as mental illness than were people who limited mental illness to "insanity"--50 per cent of the former group called "nervous breakdowns" mental illness, in comparison with 45 per cent of the latter.

The great paradox of the popular version of "nervous breakdowns" was that the more a person's description of them approximated the common "overworked-tense-uncontrolled" depiction, the less likely he was to classify them as mental illness. It may be seen in Tables 4 and 6 that the descriptions offered by people who said that "nervous breakdowns" were not clearly mental illness somewhat more frequently contained references to these symptoms. More directly, however, if a mention of either physical fatigue or collapse as symptoms, overwork as cause, or rest as cure be taken as roughly indicating those who were thinking of this "exhaustion syndrome," then, 42 per cent of those who described this syndrome classified it as mental illness, while 52 per cent of those who made no reference to

"exhaustion" regarded "nervous breakdowns" as mental illness. Similarly, those who described the tense-uncontrolled aspect of the syndrome, as indicated by mentioning any of the symptoms of loss of control, excessive weeping, tension or heightened irritability, were less likely to classify it as mental illness than those who described "nervous breakdowns" in other terms. And, once again, those who spoke in terms implying nerve damage--whether their reference was literally-meant or metaphorical--were also less likely to regard the resulting syndrome as mental illness. If these three leading elements of "nervous breakdowns" are combined, the proportion willing to classify "nervous breakdowns" as mental illness increased from 37 per cent of those whose depictions included the entire exhaustion--nerve damage--tense, uncontrolled sequence to 58 per cent of those who described "nervous breakdowns" without reference to any of these elements. (See Table 9.) The immediate influence of this imagery on judgments was sufficiently strong that, even where essentially similar syndromes had previously been offered as first impressions of mental illness or as impressions of non-psychotic mental illness, persons who repeated this description for "nervous breakdowns" were less likely to call the syndrome mental illness than were people who offered some other characterization.

These results point immediately in two directions. On the one hand, they suggest that consideration of the syndrome typified by "nervous breakdown" resulted in self-contradiction and shifting of the meaning of mental illness for most people. At the same time, however, they begin to illuminate something of the underlying logic to which people appealed in trying to decide what to call mental illness and which is, itself, a partial explanation of why there was so much inconsistency and confusion. In this instance, it is rather clear that attempts to distinguish "the physical" from "the

mental," combined with some easy assumptions about the relation between cause and effect and their relation to modes of classifying illness, contributed to confusion. In fact, the question of whether or not a "nervous breakdown" should be regarded as a mental illness largely depended on a consideration of the nature of its causes and of the logical status of the nervous system. (See Tables 27-28). Some 30 per cent of those who said it was not mental illness moved from the premise that its causes were physical to the conclusion that it was, therefore, a physical rather than a mental illness. Or, somewhat similarly, seven per cent concluded that it could not be regarded as a mental reaction because it was provoked by real problems and external stresses. These groups were, in turn, counterbalanced among those who said it was mental illness by 20 per cent who reached this conclusion because they saw the causes of "nervous breakdowns" as mental or emotional strains rather than as physical or external, and by 11 per cent who went further to conclude that the reactions of "nervous breakdowns" had no physical or "real" causes, but were "all in the mind" and, therefore, mental illness. All told, two-fifths of those who gave classifiable reasons for their classification of "nervous breakdowns" resolved the question by these causal considerations. They said:[14]

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[14] The question being answered was, "What are your reasons for saying that it is (is not) a mental illness?"

Not mental illness: It's cause is a physical sickness.

> Because it comes from bodily reasons, and not from your brain at all.
>
> Because a nervous breakdown is caused by overwork and strictly affects the nerves not the mind.
>
> It seems to me it's a physical let-down.
>
> It's a physical strain on the body that brings on a nervous breakdown.

It could be due to overwork or to anxiety over some problem or something like that, and that wouldn't be mental illness.

Mental Illness:

It is caused by a mental tension. A pressure on your mind will affect your nerves.

Because it means that a person has had mental strain and that causes a mental reaction.

The main cause of a nervous breakdown is mental exertion. I don't know of anyone who has had a physical condition that brought on a nervous breakdown. It has always been people who are worrying about financial and family trouble.

Because all illnesses must be mental or physical and a nervous breakdown ain't physical.

They are caused by imaginary happenings all centering in your mind.

Another fifth of those who explained the considerations which led to their conclusions about "nervous breakdowns" were attempting to decide whether the nervous system--which was conceived as the locus of a "nervous breakdown"--was part of the physical or mental equipment of the individual. Roughly half of this group concluded that mentality was a function of the brain and the brain, itself, part of the nervous system, from which it followed that malfunctioning of the nervous system was mental illness. The other half, however, viewed the nervous system as part of the physical realm, or, at least, as somehow not mental and, therefore, exempted malfunctioning of the nervous system from mental illness. For instance:

Not mental illness:

It's more a sickness of the nerves than it is the mind. (C) I don't think the brain has anything to do with it.

It comes from a nerve that gets weak or sometimes from just overwork. (C) Nerves are in your body not your mind.

Mental illness: Well, I think your nerves go along with the mental part of your system, and they are what breaks down.

> The nerves and the brain are altogether. When the nerves go bad, the mind is touched, too.
>
> The nerves are what make all the trouble, even if the person has a real sickness.

Beyond these causal considerations, about a third of those who discussed their reasons decided the status of "nervous breakdowns" on the basis of its characteristic symptoms. On the side of mental illness, people cited the symptoms of uncontrolled, irrational behavior, failure of self-control, deviant emotional tone and intellectual impairment as proof. On the other side, emphasis was given either to the fact that purely cognitive functions were not affected or, in short, to the fact that it was not classifiable as a psychosis. A final sixth, almost all of whom concluded that "nervous breakdowns" were not mental illness, focussed on the relative ease and rapidity of recovery from them. Illustrative of these points-of-view are:

Mental illness:

> Well, generally, I think people who've got one say and do things they don't mean and don't hardly know they're doing them. That would be mental.
>
> It's a lack of self-control, and that is mental.
>
> They are dissatisfied with life, feel they have nothing to bank on or hold to. That just isn't normal.
>
> They can't remember or think right.

Not mental illness:

> You're just as smart then as at any other time, so it isn't your mind.
>
> A person doesn't need to be insane to have a nervous breakdown. It's just a setback of the mind.
>
> Because a person can be cured of that. It's something that can be taken care of.
>
> No, if a person gets the proper treatment from a doctor, they will get well. (C) They take a lot of medicine for their nerves and they get themselves back to normal.

A more orderly account of the role of this kind of reasoning in people's thinking about mental illness and the dilemmas in which it resulted will be presented in a later chapter, where the evidence for the conclusions can be drawn together and analyzed systematically. Before that analysis can be undertaken, however, it is necessary to come to some interim conclusions about the meaning of mental illness and the consistency with which the term was used.

"Total" Impressions of Mental Illness

By the time people had finished talking of "nervous breakdowns," as the third step in this exploration of what meaning people gave mental illness, there were few left who had maintained a consistent formulation of mental illness. Thus, one-third of those who described "nervous breakdowns" in psychotic terms--some seven per cent of the entire population--had, nevertheless, been able to maintain simultaneously that they were not mental illness. And, of those who described "nervous breakdowns" in non-psychotic terms and had previously acknowledged the existence of non-psychotic mental illness, exactly half (31 per cent of all people) inconsistently excepted "nervous breakdowns" from the category. Conversely, close to a third (five per cent of the population) of those who had previously not accepted the inclusion of non-psychotic categories in mental illness described "nervous breakdowns" in non-psychotic terms, but called them mental illness. When these inconsistencies are added to those raised by a consideration of "non-insane" mental illness, little remains by way of consistent viewpoint.

As shown in Table 10, at most 28 per cent held consistently to a view of mental illness which included non-psychotic syndromes and at the same time contained neither internal contradictions nor gross

deviations from and inconsistency with the usual technical meaning of psychotic and non-psychotic. Another seven per cent of the American public consistently maintained an identification of mental illness with psychosis. For the rest, about three per cent had little or no conception of mental illness at all, while 62 per cent held views of the content mental illness which were confused, shifting and contradictory.

One major reason for this kind of confusion and contradiction about what was to be classified as mental illness was the dominance of a psychotic image in popular conceptions of mental illness. What this amounts to is that, even though most people were aware, whenever specifically reminded, that mental illness included more than psychosis, they tended to revertto an image of mental illness as psychosis whenever the more inclusive reference of the term was not explicitly stressed. An explicit definition of the term, mental illness, as including non-psychotic syndromes, taken together with an implicit tendency to use the term as if it were synonymous with psychosis, necessarily resulted in inconsistency.

Part of this inconsistency is traceable to the criteria that people used to distinguish psychotic from non-psychotic mental illnesses. About a third of the sample (34 per cent) volunteered statements that sought to make explicit the essential difference between them, but they did so, for the most part, in ways which did not correspond to psychiatric usage and which, in practice, increased their difficulties in maintaining distinctions. Thus, of those who referred to the basis on which the two were to be distinguished, 30 per cent thought of a non-psychotic syndrome simply as an earlier stage of an illness which would eventually culminate in psychosis, and this viewpoint was even more widespread than appears from these spontaneous comments. In an earlier test of the

questionnaire, a small nation-wide sample was asked directly, "Would you say that these nervous conditions can lead to insanity or not?", "How is that?"[15] Three-fourths of this sample (76 per cent) took the position

[15] This nationwide pretest was carried out a few weeks prior to the field study, using a version of the questionnaire that contained almost all the questions asked in the final study and a few additional questions which were omitted in the final version to shorten the interview. Although the pretest included only 104 interviews and cannot be regarded as a fully representative and reliable sample, it yielded results which were not significantly different from those of the final sample for every question which had been asked in common. It seems likely, therefore, that the pretest findings on questions which were not later repeated would also not differ substantially from what would have been found in the larger sample if the question had been asked, so the supplementary information which can be derived from this pretest is included, where relevant.

that "insanity" could normally be expected to result from a "nervous condition," especially if active corrective measures were not taken, while only eight per cent thought it was not usual. The typical viewpoint was:

> It's just the way insanity begins.
>
> They are going crazy, but they just haven't got there yet.
>
> They haven't gone far enough to be out of their minds yet.
>
> If you let them go, they go from bad to worse.
>
> It isn't when it first strikes, but it's bound to affect their mind, if it is left to run on.

For people who saw only this matter of the stage of development the illness had reached, mental illness was a relatively undifferentiated whole, and its phases easily merged into and became identified with its more permanent, psychotic outcome.

Another large group (31 per cent of those who stated their criteria) relied on considerations of frequency, duration and outcome to distinguish psychotic from non-psychotic forms of mental illness. Their feeling was that, no matter how extreme the symptoms, if these

were not always present in the individual's behavior, he was not psychotic. They, therefore, defined as non-psychotic any illness which was intermittant, with episodes of greater or lesser disturbance (14 per cent); any illness which was temporary, in the sense of spontaneous remission (eight per cent); and any illness which was curable (nine per cent) or involved no permanent organic damage (three per cent). For instance:

> They [the "non-insane" mentally-ill] sometimes act normal like anyone else. Their mind just seens to drift. When their mind is off, you might talk to them about something that you know they know about, and they just couldn't remember it. Then when their mind came back to normal, they wouldn't remember anything they done or said during that short period or lapse. (C) Crazy ones act like that all the time.
>
> These just go wild for a time and then they are all right again.
>
> They're the type where the brain isn't deteriorated, while the insane brain is deteriorated. Therefore, they are not mental all the time.
>
> They haven't lost their minds entirely and it's only temporary. Give them a little time, and they snap out of it.
>
> It's a temporary thing, usually, that can be treated and cured.
>
> They are still in a state where if something is done for them they can get all right.

Apart from the obvious fact that all these formulations limited psychosis to the most extreme, chronic and hopeless manifestations thereof, they also contained the logical difficulty that they rested the essential differences between psychoses and non-psychotic mental illnesses on matters which could only be determined ex post facto. Presumably, if the illness subsided, if it spontaneously remitted or yielded to treatment, it was then possible to say that it had not been psychosis, but during the course of the illness, these criteria provided no way of deciding

what it was. At moments of acute illness, the two could be identical in symptoms, and were, therefore, not actually distinguishable, until long after the fact.

The final way of distinguishing psychosis from non-psychotic syndromes turned on differences in symptomatology, which were cited by 26 per cent of those who defined criteria.[16] Here, the leading ideas

[16]There were, in addition to the views discussed in text, another 23 per cent of those referring to criteria by which to distinguish psychoses from non-psychotic syndromes who said only that the latter were a milder form of mental illness than the former. Since this statement is so general that it may imply any of the formulations that are discussed, it is not given separate attention.

were that the psychotic is violent, while the non-psychotic is not (12 per cent), and that the psychotic is out of touch with reality and not responsible for his acts, while the non-psychotic has not broken with reality (10 per cent). Much the same sort of approach was taken by three per cent who felt that the non-psychotic, unlike the psychotic, was able to continue ordinary social activities without too much impairment, and one per cent who regarded a non-psychotic mental illness as much less apparent to the superficial observer. Occasionally, the difference in symptoms was conceived in more quantitative terms, and the non-psychotic was defined as one whose aberrations, however extreme, did not extend into most of his behavior or thinking. Thus, for three per cent, the non-psychotic was the monomaniac who was much like a psychotic on some one or a few topics, but whose deviancy appeared limited to these areas. Here are some symptomatic distinctions:

> Those who are insane are to be feared. These /the "non-insane" mentally-ill/, their minds may be deranged, but they wouldn't hurt you.
>
> They're the harmless ones.

> The insane ones don't have any sense or reason; they do anything. The other mentally-ill have some control over themselves and you can reason with them.
>
> The insane can't control themselves. (C) The others can think things out and not let go.
>
> They can get along all right without having to go to a hospital.
>
> They are normal in most ways--just off about some one thing.

These distinctions based on symptomatological differences in the two syndromes did not, as the preceding ideas based on stage of development or on ultimate outcome did, tend to merge the two into an essentially undifferentiated and undistinguishable whole. Yet, these symptomatic criteria, like those based on outcome, tended to assign only the most extreme instances--the violent, completely inaccessible, or non-functioning--to the category of psychosis. Correspondingly, whichever criteria were used, the category of non-psychotic syndromes was differentiated in such a way that it included much that would be professionally classified as psychotic. And, finally, only the definitions based on symptoms --and then only those which did not depend on violence--represented formulations which were compatible with the inclusion of personality disorders in the non-psychotic category. That is, all of the criteria except those based on the extent of break with reality or the extent of functional impairment or the like were applicable primarily to behavior that marked a sharp change in the usual behavior of the personality involved. They tended, therefore, to exclude chronic, consistent personality deviations and to limit mental illness to its acute manifestations.

It may be said, then, that the popular tendency with respect to mental illness was to cut off the continuum of behavior which would be professionally accepted as mental illness at a point far above that used

by psychiatrists and, at the same time to raise the dividing line between psychoses and other mental illness to a point where psychoses become a very extreme form of mental illness. The general tendency may be portrayed about like this:

Technical Usage	Popular Usage
Severe psychosis	Psychosis
Moderate or mild psychosis Acute neurotic episode	Non-psychotic syndrome
Chronic neurosis Personality disorder	Not mental illness

This tendency to revert to psychosis as the entire content of the category of mental illness was, as might be expected, least operative among the small minority (nine per cent of those who stated criteria or three per cent of the entire public) who defined non-psychotic syndromes as representing a lesser degree of emotional deviancy or functional impairment. Of people who distinguished psychoses from other mental illness in this way, 43 per cent maintained a usage which consistently included non-psychotic syndromes within mental illness while only 22 per cent of those who relied on the duration or outcome of the illness did so. All other ways of formulating the difference fell about half way between these two extremes: of those who made the presence or absence of violence the criterion, 32 per cent were consistent, as were 32 per cent of those who made the non-psychotic form an earlier stage of psychosis, 34 per cent of those who said only that it was a milder form, and 34 per cent of those who accepted the fact that mental illness included more than "insanity" but who did not explicitly formulate the ways

in which they differed.

The operation of this tendency to "regress to the psychotic" can be further demonstrated by considering the conditions under which a "nervous breakdown" was classified as mental illness. "Nervous breakdowns," as has just been indicated, were generally described in non-psychotic terms and, consistently enough, were, therefore, more likely to be classified as mental illness by people who had initially included non-psychotic syndromes in their spontaneous descriptions of mental illness. It should be emphasized at once that it was their spontaneous image of mental illness to which people tended to refer: regardless of what people said, formally, to the question of whether mental illness was coterminous with "insanity," those whose initial impressions of mental illness were stated only in psychotic terms were about equally less likely to view a nervous breakdown as mental illness, and those who referred to non-psychotic syndromes about equally more likely to do so.

Nevertheless, despite this apparent consistency, it was the people who described "nervous breakdowns" in psychotic terms who were most likely to classify them as mental illness. When an essentially psychotic characterization was given, two-thirds said "nervous breakdown" was mental illness, and this figure was the same for those whose initial impressions of mental illness were limited to psychosis and those who spontaneously expressed a broader view:

	Per cent classifying "Nervous Breakdown" as mental illness
Nervous breakdown described as psychosis and	
First impression included non-psychotic	66
First impression limited to psychotic	66
Nervous breakdown described as non-psychotic and	
First impression included non-psychotic	56
First impression limited to psychosis	41

What is apparent, here, is that psychosis was always more likely to be perceived as mental illness, irrespective of general conceptions of mental illness. Even where mental illness had been spontaneously thought of in non-psychotic terms, the psychotic image of "nervous breakdown" was significantly more often classified as mental illness than the non-psychotic image. Yet, the spontaneous image of mental illness was not irrelevant, and the tendency to revert to looking for psychosis before seeing mental illness, though present, was not as markedly apparent for those who spontaneously thought of non-psychotic mental illness as it was for those who initially conceived of mental illness in psychotic terms. (See Table 11 for more detail.)

Tables 1-7 contain a composite view of people's descriptive definitions of mental illness, arrived at by combining into a "total" impression answers to the three questions used to investigate this topic: spontaneous first impressions, depictions of "non-insane" mental illness, and descriptions of "nervous breakdowns," where these were regarded as mental illness. This consolidation, for the most part, serves only to confirm the observations that have already been made about popular views of mental illness. Thus, in Table 2, it is apparent that, overall, the concept of "nerves," "nervousness," or "nervous disorders" and colloquial terms for psychosis were the only frequently-used ways of referring to diagnostic categories.[17] And, again, it is

[17] It should be recalled that two of the three questions were designed to elicit answers in terms of non-psychotic syndromes, while the other left it up to the person which syndromes he discussed. This fact, alone, would make for a lower frequency of use of popular psychotic equivalent labels as compared with non-psychotic ones, so the relative frequency of the two most-used categories is not accurately determined by these data.

clear, in Table 3, that these were, in fact, generally references to non-psychotic syndromes and psychoses, respectively. It can also be seen in Table 3 that the tendency to use categories which were more typically used as equivalents for non-psychotic syndromes to refer to essentially psychotic manifestations was consistent. About two-fifths of the time people who stated diagnostic categories referred to psychoses as "nerves," or allied terms. It is similarly apparent, in Tables 4-7, that the cumulative effect of the three separate discussions of mental illness is to increase the frequency with which various summary characterizations and specific descriptions were used, without much change in their relative frequency.

Nevertheless, because of the shifting meaning of the term, mental illness, as popularly used, these "total" impressions syould be treated with caution, especially where they bear on the inclusiveness of the concept of mental illness. Thus, it is shown in Table 1 that over this set of questions, 75 per cent of the American public did, at least part of the time, actually include non-psychotic syndromes in what they called mental illness. Yet, it must not be overlooked that they were not always aware that these syndromes would be technically classified as non-psychotic and, more important, about three-fifths (62 per cent) of them vacillated in their willingness to include the non-psychotic. Similarly of the 22 per cent who included only psychosis within mental illness, less than a third (30 per cent) were completely consistent in their usage.

Considering that this picture of wide-spread uncertainty, conflict and inconsistency as to the meaning of mental illness resulted from public discussion of only three of the many questions which might have been posed (and is "total" only in the sense of summing up the relevant material in this particular research), it is inevitable that not all of the

difficulties of the average person in dealing with the concept of mental illness have been uncovered here. There is, therefore, every reason to conclude that there was neither general consensus nor individual clarity about the way the term, mental illness, was defined. In the next chapter, we shall turn to the way in which mental illness was applied to concrete examples of human behavior and the status of the concept of mental illness within the total explanatory scheme popularly applied to human behavior.

CHAPTER 4

POPULAR INTERPRETATIONS OF HUMAN BEHAVIOR: SIX PEOPLE IN ACTION

Introduction

Mental illness is, after all, an abstract concept applicable to a heterogeneous class of human behaviors, and how people define this term may well be less important than how they deal with concrete, individual personalities, whatever they call them. Surely, the public's ability to recognize disturbed personalities, to accept them without shame, fear or condemnation, and to take appropriate measures in preventing or ameliorating their disorders is more important than mere quibbling about what terminology should be used in referring to them.

Nevertheless, the absence of terms which conveyed unambiguously what was meant by mental illness and, indeed, the general lack of either public agreement or individual consistency about what was included under the heading of mental illness was, in a way, presumptive evidence that public recognition of and information about mental illness were in a similarly confused state. Certainly, it is reasonable to assume that the common language always contains words or concepts by means of which whatever is commonly perceived and recognized can be pointed out. If shared, well-defined terms were missing from popular vocabulary, it must be that they were not needed--that there was no common perception of the human behaviors technically classed as mental illness, and, therefore, no widely-accepted, socially-defined words by which to refer to them. While it is difficult to see how the situation could have been otherwise, documentation that more than a question of semantics was involved in confusion over the meaning of mental illness can be obtained more directly, by asking how people actually did classify and account for typical, concrete instances of human behavior.

Six thumb-nail sketches, describing the personality and behavior of hypothetical individuals in terms which actually typified one degree or another of mental disorder,[1] were presented to the public. People were

[1] A number of psychiatric advisors, acknowledged in the preface, assisted in the preparation of these descriptions and agreed that they described recognizable mental disorders.

asked, in each instance, to classify the person, to account for how he came to be that kind of person and, to explain the logic by which they included that kind of person in the category of mental illness or excluded him from it. These six examples, whose "life stories" make up the materials of this chapter, were:

Paranoid[2]: Now I'd like to describe a certain kind of person and ask you a few questions about him...I'm thinking of a man--let's call him Frank Jones--who is very suspicious; he doesn't trust anybody, and he's sure that everybody is against him. Sometimes he thinks that people he sees on the street are talking about him or following him around. A couple of times, now, he has beaten up men who didn't even know him, because he thought they were plotting against him. The other night, he began to curse his wife terribly; then he hit her and threatened to kill her, because, he said, she was working against him, too, just like everyone else.

[2] The psychiatric classification of each example is indicated at the beginning of the description but was not, of course, presented to the people asked to discuss the case.

Simple Schizophrenic: Now here's a young woman in her twenties, let's call her Betty Smith...She has never had a job, and she doesn't seem to want to go out and look for one. She is a very quiet girl, she doesn't talk much to anyone --even her own family, and she acts like she is afraid of people, especially young men her own age. She won't go out with anyone, and whenever someone comes to visit her family, she stays in her own room until they leave. She just stays by herself and day-dreams all the time, and shows no interest in anything or anybody.

Anxiety Neurotic: Here's another kind of man; we can call him George Brown. He has a good job and is doing pretty well at it. Most of the time he gets along all right with people, but he is always very touchy and he always loses his temper quickly, if things aren't going his way, or if people find fault with him. He worries a lot about little things, and he seems

to be moody and unhappy all the time. Everything is going along all right for him, but he can't sleep nights, brooding about the past, and worrying about things that might go wrong.

Alcoholic: How about Bill Williams? He never seems to be able to hold a job very long, because he drinks so much. Whenever he has money in his pocket, he goes on a spree; he stays out till all hours drinking, and never seems to care what happens to his wife and children. Sometimes, he feels very bad about the way he treats his family; he begs his wife to forgive him and promises to stop drinking, but he always goes off again.

Compulsive-Phobic: Here's a different sort of girl--let's call her Mary White. She seems happy and cheerful; she's pretty, has a good enough job, and is engaged to marry a nice young man. She has loads of friends; everybody likes her, and she's always busy and active. However, she just can't leave the house without going back to see whether she left the gas stove lit or not. And she always goes back again just to make sure she locked the door. And one other thing about her: she's afraid to ride up and down in elevators; she just won't go any place where she'd have to ride in an elevator to get there.

Childhood Conduct Disturbance: Now the last person I'd like to describe is a twelve year old boy--Bobby Grey. He's bright enough and in good health, and he comes from a comfortable home. But his father and mother have found out that he's been telling lies for a long time now. He's been stealing things from stores, and taking money from his mother's purse, and he has been playing truant, staying away from school whenever he can. His parents are very upset about the way he acts, but he pays no attention to them.

After each description was read, each person was asked the following sequence of questions:

What do you think makes him /her/ act this way? (PROBES: What's causing him /her/ to act like this? What happened to make him /her/ like this? How does a person get to be this way?)

Would you say this man /young woman, boy/--Frank Jones /Betty Smith, George Brown, Bill Williams, Mary White, Bobby Grey/--has some kind of mental illness or not?

Why do you say that he /she/ has (does not have) a mental illness?

(IF APPLICABLE) Would you say that the mental illness he /she/ has is a serious one or not?

Why do you say it is (is not) serious?

Identification of Mental Illness

The way in which these sketches were dealt with by the public confirms what has gone before, so far as the popular definition of the term, mental illness, is concerned. As shown in Table 12, it was only the relatively extreme form of non-institutionalized psychosis, illustrated by the violent, paranoid behavior of "Frank Jones," that was perceived as mental illness by a majority of the public and, even with an extreme example like this one, one-fourth of the public maintained either that there was nothing wrong with him or that whatever was wrong was not or need not be mental illness. Only a third of the public recognized the concrete example of incipient simple schizophrenia as mental illness, and almost as large a group saw nothing problematical about "Betty Smith's" "quietness." The form of alcoholism typified by "Bill Williams" was classified as mental illness by only 29 per cent; "George Brown's" anxiety neurosis, by 18 per cent; the disturbed child, by 14 per cent; and the compulsive-phobic "Miss White," by 7 per cent.

Overall, one-sixth of the public did not perceive mental illness in any of the six cases, while one-third saw only one of them--generally the paranoid--as mentally ill. Thus, just under half the public--45 per cent--either did not perceive mental illness at all or recognized only the violent manifestation of it, and a clear majority--57 per cent--classified none of the four non-psychotics as mentally ill. Among the 43 per cent who recognized at least one of the non-psychotics, a third singled out only the sociopathic disorder of alcoholism and a half recognized only the overtly anti-social trends exhibited either in alcoholism or in the stealing and truancy of the child. In all, then, only a fifth of the public recognized as mental illness the less dramatic but more frequent symptomatology of either neurosis or neurotic trends,

presented in the stories of "George Brown" or "Mary White." (See Table 13.)

If the instances of alcoholism and childhood conduct disturbance are left aside as raising special problems because of the socially-disapproved behavior they exhibit, the four remaining examples can be shown to constitute, in popular thinking, a single continuum, representing degrees of severity of mental illness from personality disorder to neurosis to non-violent psychosis to psychosis. That is, when the cases are ranged from the seemingly-mild compulsive-phobic trends of "Mary White" to the paranoid behavior of "Frank Jones," generally speaking, respondents who recognized the personality disturbance as mental illness also recognized the more severe neurotic and psychotic syndromes, those who recognized the anxiety neurosis also recognized both psychotics, and those who recognized the non-violent psychotic also recognized the violent one.[3] On the basis of these four examples, then, concepts of mental

[3]The four items form a Guttman scale--a demonstration of the presence of a single dimension--with a reproducibility, based on the entire sample of 3,531 interviews, of 97.1 per cent.

illness, at least so far as recognition of concrete instances is concerned, emerge as:

Included both personality disorder and neurosis. . .	4%
Included neurosis, but not personality disorder . .	8
Limited to psychosis, generally	18
Limited to violent psychosis only	39
Apparently no recognition of mental illness	20
Usage not consistently classifiable above	11
	100%

This relatively low perception of mental illness in the concrete behavior of individuals was, of course, related to the way in which people had generally defined and used the term, mental illness. It can be shown, for example, that people who said mental illness included more than

"insanity," people who classified "nervous breakdowns" as mental illness, and people who included non-psychotic syndromes in their descriptions of mental illness were more likely than their opposites to perceive each of the six hypothetical persons as mentally-ill. By way of summary, Table 14 shows the relation of the kind and consistency of usage in the three-question discussion of mental illness in the abstract to the likelihood of classifying concrete instances as mental illness. It is apparent that those who adhered to a general usage which consistently included non-psychotic syndromes were most likely to regard each example as mentally-ill, and, within this group, those who had spontaneously included them, prior to direct questioning, in their first impressions of mental illness were somewhat more likely to do so. People whose usage contained inconsistencies, irrespective of whether or not they sometimes included non-psychotic syndromes, were a good deal less likely to perceive mental illness in these six personalized illustrations, especially where the non-psychotic illustrations were concerned. In comparison with those whose usage was consistently non-psychotic, people who were inconsistent were only about half as likely to perceive mental illness in each of the four non-psychotic examples and about twice as likely to perceive none of the six as mentally-ill. Finally, it is noteworthy that people who employed an apparently consistent usage which limited mental illness to the psychoses, were not merely, as might be expected, least likely of the five types of usage to perceive the non-psychotic examples as mentally-ill, but were also least likely to recognize the two psychotic instances. (This statement leaves out of account the small group who appeared to have no impression of mental illness, who seldom identified any of the examples as mentally-ill.)

Nevertheless, lack of perception of mental illness in the forms in which it was portrayed in the six examples went far beyond considerations of definition and consistency of usage of the term, mental illness. When full account is taken of the elements in usage which could be derived from the earlier general discussion of mental illness, as in Table 14, the violent paranoid remained the only instance of the six where a majority perceived mental illness, even in the group most likely to perceive mental illness. To put it another way, among those whose discussions of mental illness in the abstract had consistently and from their first spontaneous remarks included non-psychotic syndromes, only a fifth, in practice, consistently recognized concrete non-psychotic syndromes. While this proportion is higher than that of any other usage group, it still indicates a great disparity between abstract definition and concrete application of mental illness as a classifying term.

The fact that there was relatively little carryover from discussions of mental illness in general to the treatment of these individual instances can be demonstrated even more dramatically by considering only those people who had, themselves, described mental illness in much the same terms as characterized individual examples. "Frank Jones," for instance, was clearly presented in terms of violence, aggressiveness and exaggerated suspiciousness and, as such, fitted fairly well the popular image of psychosis. Yet, among those who had volunteered these key symptoms for mental illness, 79 per cent thought "Frank Jones" was mentally-ill, as compared with 74 per cent of those who had not explicitly mentioned such symptoms of mental illness. If, to be doubly-sure, this comparison is limited to the group who also referred to these symptoms in discussing "Frank Jones"--a subgroup for whom it is unequivocal that he was actually perceived in the

terms in which he was presented and intended to be seen, the difference is, again, beyond chance expectation but hardly impressive: 77 per cent of those who mentioned the symptom complex both for mental illness generally and for "Frank Jones" saw him as mentally-ill as over against 73 per cent of those who viewed "Frank Jones" in terms of these traits but had not explicitly assigned them to mental illness. Differences of about this order also held true within usage groups, although it is clear that general consistency in usage was more closely related to perceiving mental illness in a concrete instance than was apparent similarity in descriptions of mental illness and the particular instance. Thus, within the group who perceived "Frank Jones" in terms of the violence-aggression-suspicion complex and who had adhered to a consistent inclusion of non-psychotic syndromes within mental illness, 86 per cent of those who had sketched the same symptoms for mental illness called him mentally-ill, while 80 per cent of those who had not given such symptoms for mental illness did so.

Similarly, "George Brown," was described as a "nervous" man--tense, anxious, irritable and insecure, and this description corresponded almost exactly with the popular image of a non-psychotic mental illness.[4] Of those

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[4]Only the illustrations of "Frank Jones" and "George Brown" are presented here, just because they best represent popular images of mental illness. With examples like "Bill Williams," "Bobby Grey" and "Mary White," their leading characteristics had been mentioned too infrequently as symptoms of mental illness to permit this kind of comparison. The comparison was made for "Betty Smith" in terms of withdrawal, insecurity and anxiety with much the same kind of results as are presented.

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who had described a similar syndrome for mental illness, 20 per cent said "George Brown" was mentally-ill as compared with 15 per cent of those who had not referred to this anxiety complex in connection with mental illness. Within the sub-group who explicitly characterized "George Brown" with these traits, the comparable figures were 22 and 18 per cent. In contrast, among

those who described his personality in this way and who had previously consistently included non-psychotic syndromes in mental illness, 32 per cent said he was mentally-ill, and the figure was the same for those who had explicitly mentioned the anxiety complex in connection with mental illness and those who had not.

All in all, then, these results appear to point toward a simple conclusion that even more inconsistency and contradiction entered into people's use of the term, mental illness, than the previous chapter indicated. While this conclusion is at least partially warranted, something more important is involved. Up to this point, the popular meaning of mental illness has been wholly derived from descriptive materials: certain actions, feelings, ideas, etc. were ascribed to the mentally ill, and these have either been used directly or been reduced to short-hand, summary labels, roughly indicating what symptom-complexes were being described. If the descriptions offered had been exhaustive, we could be sure that every instance of mental illness would display one or another of these descriptive items. It would not logically follow, however, that every instance of behavior which could be described in these terms would be classified as mental illness. While these descriptive elements are necessary to defining what was popularly meant by mental illness, there is no reason to assume that they were popularly regarded as sufficient. What is thus far missing from our depiction of popular impressions of mental illness is some definition of the other conditions to be met before behavior which fits the descriptive requirements of mental illness was actually so to be classified.

From this point of view, mental illness must be regarded as one of a number of abstract categories which together comprise a system for classifying, interpreting and understanding human behavior. And, so far as the recognition of mental illness in the concrete examples is concerned, it is

obvious that there was something about this interpretive scheme and the role assigned to mental illness within it which militated against classifying these hypothetical people as mentally-ill, even when they fitted prior descriptive definitions of mental illness.

Before popular conceptions of mental illness can be fully depicted and understood, then, it will be necessary to examine the ways in which human behavior was generally approached and accounted for and the implications of this interpretive scheme. In order to simplify the presentation, we shall first present a full account of the way in which each of the six examples was explained; from these concrete discussions, it will then be possible to abstract the more generic features of the causal system popularly employed, and, finally, their implications for the meaning of mental illness will be traced.

The Story of "Frank Jones"

"Frank Jones," it will be recalled, was described as exhibiting violent paranoid symptoms and was usually perceived as mentally-ill. Among those who classified him as mentally-ill, 71 per cent regarded his illness as serious, a proportion which approximately equated his illness with alcoholism as the most serious of the six syndromes described. In terms of differential diagnosis, which was mentioned by only a third of those who regarded him as mentally-ill, "Frank Jones" was classified as psychotic or incipiently psychotic by about a three to one ratio. (The relevant data appear in Table 15.)

When "Frank Jones" was not classified as mentally-ill, he was generally regarded as an instance of a particular kind of personality structure, which was usually described in the neutral terms of temperament, conditioning or personality, but was sometimes couched in terms of moral condemnation of the individual as a character defect or a deliberate, willful choice of disapproved conduct. People did not generally speak in exactly these terms, of

course, but an implicit concept of some form of psychological organization which had more permanence than immediate emotional responses and more individuality than reactions which might be regarded as universal to human beings underlay the comments made by three-fourths of those who did not regard "Frank Jones" as mentally-ill, and three out of four of these people used naturalistic rather than moralistic formulations. In the few instances where neither mental illness nor personality structure was the organizing principle, people conceived of "Frank Jones" either as having an emotional or nervous illness--which might be only semantically distinct from mental illness; as being physically ill; or as making the expected human response to the particular circumstances in which he found himself. (See Table 16.)

These alternate ways of characterizing the general significance of "Frank Jones'" behavior did not differ greatly between those who defined his actions as problematic (though not mental illness) and the minority who saw "nothing wrong" with him. There was a slightly more frequent use of formulations employing the idea of illness on the part of those who viewed "Frank Jones" as having "something wrong" other than mental illness, while those who viewed him as non-problematic and conceived of him in terms of personality were somewhat more likely to take a moral approach to personality.[5] (See Table 17.)

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[5]At first glance, it may appear odd that a person can be simultaneously classified as saying the behavior represented illness and saying that there was nothing wrong with the man. This seeming paradox is easily explained, however, by the fact that the classification is our interpretation of the significance of the respondent's remarks, while the "nothing wrong" represents the respondent's own evaluation. Thus, we classified as "physical disorder" the following interpretation: "No, there's nothing wrong with him. He's just tired and run-down. You know, when you're not feeling good, you get a lot of peculiar notions in your head." Here, of course, the "nothing wrong" is used to indicate both that the behavior is transient and to be expected because of or adequately explained by the abnormal physical condition and that the physical condition is not very serious. "Nothing wrong" was also sometimes employed to underscore condemnation by denying the existence of any morally acceptable explanation: "Indeed, there isn't anything wrong! There's just no excuse for a man acting like that."

Regardless of the general rubric under which their interpretations could be subsumed, most people began their causal explanation of "Frank Jones'" behavior on a descriptive level. Over 90 per cent of the public incorporated some kind of psychological description and interpretation into their accounts, and 80 per cent carried their discussion beyond spontaneous classification or categorization of the man as an instance of mental illness to either an identification of personality traits, a characterization of personality type or an interpretation of the psychological mechanisms underlying his behavior, as shown in Table 18. Some typical instances of this kind of discussion were[6].

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[6] These illustrations are generally in answer to the question: "What do you think makes him act this way? (PROBES: What's causing him to act like this? What happened to make him act like this?)" Spontaneous comments, offered after the description was read, but before this question was asked, are preceded by (S). As before, (P) indicates a reversion to the initial question in one of its forms, either to bring the discussion back to the causal level or to explore other causal sequences. (C) again indicates that preceding material was being clarified, but this clarification usually took the form of inquiring into the causes lying behind the particular step in the causal sequence that had just been discussed.

He has a nervous condition, but he isn't crazy or insane.

(S) It's a form of mental illness. (P) He likes to persecute himself.

He could be the jealous type, a little off balance, not all normal.

(S) He's just mean. (P) Nothing happened to him, he's just mean and evil. (C) He don't care how he acts.

He's lost his trust in people I guess. (C) He just has a suspicious mind.

Anyone like that is a super-egotist. He has thought of himself so much that every thought is of himself. Along with being a super-egotist, he is also fighting a superiority complex.

He probably doesn't recognize the truth when he sees it. I expect he needs to take a little self-inventory. He probably isn't very honest with himself. (C) He probably isn't emotionally grown up. (C) He lets little things bother him. (C) I'd say he's having a nervous upset of some kind.

He's stupid, that's one thing, and I'd say he has a "jealousy" nature.

An inferiority complex. (C) Suspicion is brought on by an inferiority complex, or being a self-centered introvert.

(S) An ugly man. (P) An inferiority complex, and he blusters around, covering up, and acts like a bully to prove he is the best man.

He might be just so mean himself, he thinks everyone else is.

In this descriptive interpretation of "Frank Jones," the leading characterization was that he was a suspicious, distrustful man--42 per cent offered this restatement, occasionally in the form of references to his having a persecution complex, but more frequently in such terms as: "he doesn't trust anybody," "he's suspicious of people," "he believes everyone is against him," "he's lost his trust in people." As the high frequency with which this description was repeated indicates, people who mentioned it were usually simply focussing their explanations of "Frank Jones" on the trait they considered central. Almost as frequently as they employed this preliminary summary, people reacted with an immediate diagnosis of mental illness, before this question was specifically raised. These descriptive elements are summarized in Tables 19 and 20.

Aside from these two broadly-orienting descriptive comments, there was not very general agreement on the psychological trends perceived to be operating in "Frank Jones." Since the trends singled out do indicate the kinds of psychological mechanisms employed in explaining him, they are, despite their infrequency, worth some attention. Most frequent of these was the perception of "Frank Jones" as an insecure, self-conscious person, one who lacked confidence in himself. Some 15 per cent made this interpretation and

three per cent used a subvariant in which he was viewed as feeling rejected or sorry for himself. About half the people who spoke in these terms identified the trend, explicitly, as an inferiority (or "inferior") complex. Occasionally, as in one of the illustrations already cited, these feelings of insecurity or inferiority were described as part of a compensatory mechanism in which his current behavior was viewed as an attempt to conceal, deny or make up for his inner feeling of inadequacy. (Less than a tenth of those who gave central attention to "Frank Jones'" insecurity spoke of it in this context of self-concealment, self-aggrandizement, and compensation.) More typically, however, insecurity was viewed as logically including insecurity in personal relationships, with consequent attitudes of distrust and suspicion toward others, or the distrust might be viewed as a response to the projection onto others of the belittling way in which "Jones" regarded himself. Thus, the mechanism was usually sketched out as: "people who lack confidence in themselves, or who feel inferior or insecure are generally uncomfortable in their personal relationships also. They may simply feel generally uneasy or unsafe with other people, or they may suspect others of undervaluing or disliking them, but in either case they are suspicious and distrustful of others." This statement is, of course, a highly rationalized account, but people who used this basic interpretation said things like:

> People who don't have confidence in themselves don't have confidence in others, either.
>
> Lack of security could do that, not feeling wanted by others.
>
> He feels inferior to those people; therefore, he thinks they are against him.
>
> (S) He's got an inferiority complex. (P) That's why he acts like he does now: he feels like an underdog and suspects everyone of being down on him.

Essentially similar in viewpoint were the eight per cent who viewed his suspicion and distrust as a concrete manifestation of an underlying, general

anxiety or fearfulness.

A second main theme was to view "Frank Jones" as a hostile, aggressive personality, or, as it was more frequently expressed, as a man with a "mean," "ugly," or "bad" disposition. Twelve per cent described him in this way, while another five per cent conceived of his aggressiveness in terms of resentment and retaliation. Frequently, this description was an evaluation of the man and was not linked to any further psychological process. It was, however, also used in the context of projection. In its simplest form, this interpretation described him as an unpleasant or undesirable character who judged everyone by himself and acted toward them as he should be acted toward. Thus, we have the person who said, "He might be just so mean himself, he thinks everyone else is"; and similar comments like, "Anyone who can't see any good in anyone else is not any good himself." Or, the aggressiveness was sometimes formulated as a compensatory response to feelings of inadequacy, as with the person who said, "He's a bully, and all bullies are cowards at heart." Aggressiveness was also sometimes placed in a more complex context as a reactive response to the criticism of himself which he had projected onto others. Here, of course, he was retaliating against others whom he regarded as themselves hostile, critical and rejecting toward him.

The last of the more frequently-used psychological themes revolved around feelings of guilt or actual wrong-doings. In this version, sketched by about 11 per cent, "Frank Jones" knew, suspected or feared that others had discovered or might discover his guilty secret, whether this was real or imaginary. For instance:

> His conscience is bothering him.
>
> Excessive suspicion is sometimes a betrayal of one's own guilty conscience.
>
> Lots of times, maybe, they aren't doing the things they should be doing in order to live a good, honest life, and they get to imagining things.

> I think he's done something awful wrong--maybe, stolen or killed, and his sin is on his mind. It makes him suspicion people; he's afraid they'll find out.

In addition to these psychological processes, only two others were mentioned in connection with "Frank Jones" by as many as five per cent of the public. These were, first, a tendency on his part to brood or allow things to "prey on his mind" and, second, overimaginativeness. When tendencies like these were used in a sense other than sheer identification or naming of his behavior, they usually served--as did the less frequently mentioned qualities of lack of self-control or lack of adequate perspective on life--to explain the mechanism by which some experience could come to dominate his outlook so completely. In this point of view, his behavior resulted from a variety of previous experiences which he failed to evaluate correctly, allowed to assume obsessive proportions, or about which he had brooded or given free play to his imagination. Since this connecting link between experience and behavior will be further explored in connection with the kinds of experiences called upon to explain his behavior, this brief summary may suffice at this point.

Suspicion, mental illness, insecurity or anxiety, aggression, guilt, and obsessive, biased, uncontrolled thinking--these were the main formulations of the psychological significance of "Frank Jones'" behavior. A host of other psychological tendencies were also mentioned, but they were each used infrequently, and were generally introduced in elaboration of one or another of these main themes. Of the four-fifths of the public who spoke in terms of any kind of concrete personality depiction or analysis, 86 per cent used some part of these five main themes, and 58 per cent did so without reference to other psychological considerations. So, as shown in Table 21, about a fifth of the public gave more elaborate accounts of the basic psychological trends than can be presented systematically, roughly half were rather fully and adequately represented by the themes discussed, and only nine per cent

used psychological interpretations that departed from them in major respects. (Twenty per cent, as mentioned earlier, had not introduced this kind of psychological discussion into their accounts.)

While it may come as something of a surprise, the varying kinds of psychological tendencies and mechanisms which were perceived to be operating in "Frank Jones'" Behavior, had relatively little to do with whether or not his behavior was viewed as problematical. As presented in Table 21, only three of the leading psychological interpretations varied significantly among those who classified him as mentally-ill, problematical in some other sense, and non-problematical, once an allowance is made for the fact that those who regarded him as non-problematical were most likely to speak in psychological terms, while those who called him mentally-ill were least likely to.[7] That is,

[7]This leaves out of account the kind of psychological description involved in volunteering the classification of mental illness, all of which, of course, occurred in the latter group.

people who called "Frank Jones" mentally-ill were most likely to describe him as suspicious and as brooding over his real or imagined wrongs, while those who saw "nothing wrong" with him were least likely to. Conversely, people who regarded him as non-problematic were most likely to perceive him as a hostile, aggressive, ugly personality, while those who perceived mental illness were least likely to perceive him in these essentially morally-condemnatory terms. Despite these differences, however, the leading characterization of "Frank Jones" was the same in every classification. Regardless of whether he was classed as mentally-ill, as non-problematic or as something between, the most frequent psychological perception was that he was suspicious and distrustful; and suspicion, insecurity and hostility were the three most frequently mentioned tendencies in each of these general classification groups.

It is, thus, apparent that, while there were some differences in the

way in which "Frank Jones" was perceived, the way in which he was classified was not, primarily, a function of these differences in perception. Since the tendency to classify "Frank Jones" as mentally-ill, as abnormal in other respects or as normal is not, for the most part, to be explained either by variations in general conceptions of mental illness or by differences in the way the presentation of "Frank Jones" was comprehended, we may turn, for further clarification, to the next logical element in discussing "Frank Jones"--causal explanations of his behavior.

For 29 per cent of the public, explanation of "Frank Jones" stopped at or before the level of psychological interpretation that has just been presented. For three per cent of the population, the only answer to the question of "Frank Jones" was that they did not know how to account for him. For some 11 per cent, however, it must be admitted that this outcome is ambiguous, since the people involved neither explicitly said that the psychological elements they used were the ultimate causes of his behavior, nor did they attempt to explain or state their inability to explain the possible causes of the psychological trends they had discerned.[8] For the rest, however, eight per cent simply

[8] Instances of this sort sometimes represented interviewer carelessness, oversights or failures to explore completely what people said. In other cases, however, interviewers employed a large number of subsidiary probes without getting outside the psychological realm, from which they concluded that these respondents did not think in terms of causes of the psychological processes, even though explicit confirmation of their judgment was lacking.

said that they did not know how to account for the establishment of the psychological processes currently determining "Frank Jones'" behavior, and seven per cent stated, in one form or another, that causal explanation could not be carried further. (See Table 18.) In this latter group were about two per cent who explicitly viewed personality structure as innate, one per cent who strongly implied its inherent origin, and four per cent who accounted for "Frank Jones'"

behavior in terms of decisions, choices and actions within his conscious control. The total number of people who explained "Frank Jones" in this way was twice as large: some 14 per cent (a fifth of those who made any sort of causal explanation) traced his behavior to his personality or willed actions, but half of them also gave alternative causal explanations. (See Table 22.) This line of causal explanation is expressed in the following discussions:

> Sometimes it's just in them to be not agreeable with people. (C) It's just born in them.
>
> It's a sickness, it's jealousy--that can make a man do anything. (C) He's just so jealous he's about half-way crazy. (C) He thinks everybody is just like him: he's against everybody, so he thinks everybody is against him. (C) Some people are just naturally born like that.
>
> He probably has an inferiority complex. (P) Maybe paranoia. (C) A persecution complex. (C) With a persecution complex, you are born with it. (C) With an inferiority complex, the parents.
>
> (S) He's just mean or crazy or losing his mind. (P) Nothing happened to him, he's just mean and evil. (C) Maybe he's sick in the head, but I doubt it. (C) I would rather think he's just mean and evil and don't care how he acts.
>
> His mind is weak from some cause. (C) A lot of people who get that way just get that way and don't want to be any different. They get jealous maybe. (C) Oh, I don't know, he may imagine most anything. He just has let these things get into his mind and thinks things are just that way.
>
> (S) He needs to go to church. It's as much of an evil spirit as anything I know. (P) They are self-conscious sometimes. He must have done something and he thinks people will do the same thing. (C) It's the old satan in him, and he could be all right if he joined the church and quit his evil ways.
>
> He must have done something to think people are talking about him. There must be a fear in his mind. (C) Fear that he'll be found out. (C) He may have stolen something or committed some crime. (C) He's dishonest, that's why.

This explanation of personality by innate characteristics, personality itself, or its manifestations in volitional action, as well as the tendency to terminate discussion of the behavior without departing from the descriptive level,

was associated with a view of "Frank Jones" as non-problematic and, more particularly, as a morally-disapproved personality. Apparently, people who disapproved strongly of his behavior chose to express their judgments rather than to offer a neutral explanation. (See Tables 23 and 24.)

As with these psychological approaches, causal explanation of "Frank Jones'" behavior tended to concentrate on factors in his current life or his immediate past. As Table 25 indicates, roughly two-thirds of the causal explanations for which a time reference could be inferred dealt with his adult life. And this present-time orientation was the typical approach, irrespective of the basic forumation of the nature of his difficulties. Even when "Jones" was conceived of as a personality type or an instance of conditioning, the most frequent explanation was one involving only his adult life. (See Table 26.)

Apart from the immediacy of the explanations, however, causal interpretation of "Frank Jones" proceeded in four main directions, in addition to the psychological. About 29 per cent offered explanations of "Frank Jones" in organic terms, these being primarily people who attributed his behavior to mental illness and went on to explain the causes of mental illness, generally, rather than the causes of his specific behavior. For this group, "Frank Jones" was mentally-ill, and mental illness was the result of poor heredity, injuries to or diseases of the brain, organic damage resulting from prolonged use of alcohol and the like. More diffuse organic explanations traced his behavior to physical strain or fatigue or to a generally weakened or susceptible constitution, and this type of causal explanation was frequently associated with a perception of "Frank Jones" as physically or nervously ill. When physical factors were used in a context other than illness, his behavior was regarded as the "natural" or typical response to transient physical states. But these organic explanations, and, especially, those which asserted or predicated direct damage to the brain or nervous system, were much more likely to be employed

by those who perceived mental illness than by those who did not. The points-of-view subsumed within the organic are exemplified in the following remarks:

> (S) It is a mental disorder. (P) It's caused by a brain disturbance; it's definitely a brain disease. (C) An injury to the brain.
>
> (S) Mentally-ill. (P) He could have had an injury to his head. A doctor I knew, when he was in the Army, froze one side of his head, and he is mentally unbalanced from that.
>
> He has a mental deficiency there. (C) Well, he could have had a physical ailment that left him in that shape or been a drunkard and that left him like that. And it could have been that his forefathers had venereal disease and he inherited it, or maybe he caught it himself.
>
> He had a nervous breakdown, was mentally sick. (C) It could be different things. (C) Overwork, drinking too much, lack of proper rest.
>
> Some chronic sickness could be causing him to be like that. (C) Chronic appendicitis, earache, or eyestrain, or not enough sleep from drinking coffee.
>
> (S) I would say he has a mental disorder. (P) Because he has a mental disorder. (C) It could be drinking, or it could be something in his mind that snapped, or it could be the beginning of insanity.
>
> It's caused from drinking too much. They get whiskey into them, and then they're as mean as can be. Of course, they're all right again when they sober up.

A second and equally-large main group of causes centered around the current circumstances of Frank Jones'" existence, with these environmental factors conceived of as rather impersonal stresses and strains to which "Frank Jones" reacted. Thirty per cent of the public used this basic approach in dealing with "Jones," the main theme being that "money troubles" and "family troubles" shaped his responses. As with the organic types of causes, this "environmental-stress-and-strain" viewpoint was most typically used to explain generic causes of mental illness or of nervous disorders, after "Frank Jones," had been subsumed within one of these categories. On the other hand, this kind of "environmental determinism" also lay at the foundation of

the reasoning of the relatively small number of people who viewed "Frank Jones" as responding as any human being could be expected to respond to the peculiar situation in which he found himself. Thus:

> (S) He's on the way already. (P) It may just be due to too many current problems at once.
>
> He is a neurotic, a mental case. (C) He is on the verge of a nervous breakdown. (C) He may have had financial worries or family worries.
>
> It's an extreme case of worry. (C) Over his job or finances or employment. A feeling of insecurity accompanies it, so he begins to suspect people.
>
> I believe it's his nerves. (C) They work up in the head and affect his brains. (C) Trouble. (C) Through money, or bad luck, or through family--deaths or sickness.
>
> (S) I'd say he was about insane. (C) A good many things could: maybe things at home didn't work just right. (C) He can't get along with his wife. Then he could be worried about money or debts.
>
> Someone dear may have died, and his mind wanders from that.
>
> He's not doing right, but maybe it's because he's not getting ahead, and if things went right for him he'd be all right.

Generally speaking, then, organic processes and environmental stresses were discussed as factors in "Jones'" immediate situation which produced an abnormal condition--mental illness or other illness--in him. This abnormal condition, in turn, was responsible for the symptoms he exhibited. When this interpretive scheme of identifying the behavior with illness and causally explaining the illness was employed, there was, of course, little attempt to account for the individuality of "Frank Jones" or for the concrete form the manifestations of his abnormal condition assumed. In the two remaining main causal lines employed, however, the emphasis was on accounting for the specific personality or behavioral patterns which had been perceived in "Frank Jones." Both of these approaches revolved essentially around interpersonal

relationships, but with a difference in underlying assumptions.

The less-frequently used of these interpersonal causal interpretations was one which located personality determinants in the interpersonal experiences of early life in a way that may be regarded as at least roughly incorporating modern psychological viewpoints. For the 11 per cent who used causal reasoning of this kind, "Frank Jones'" personality was shaped by lack of love in his childhood, by too strict and repressive an upbringing, by an overindulged, overprotected childhood, by parental failures to inculcate moral standards and the like. These relationships, thus, clustered around ideas of emotional deprivation and frustration, on the one hand, and a more morally-oriented concept of overindulgence and lack of moral training, on the other, with the former theme dominating by about two to one. People who adopted this approach to "Frank Jones" said:

> I would think it goes a long way back to his childhood. Some family derangement occurred to cause him to distrust people. (C) Probably marital trouble between his parents.
>
> He probably has an inferiority complex as a result of an unhappy childhood. (C) The chances are his parents didn't give him enough affection. Or they might have been too domineering.
>
> He has a mental illness. (C) It could go back to his childhood; psychologists trace it back to childhood. (C) Maybe lack of security could do that, not feeling loved by others.
>
> He has not been loved enough as a young child, nor given any attention. He had very selfish parents that probably didn't want him.
>
> People say there's childhood disappointments can cause that, too. (C) He didn't have very good parents or very good wisdom used in his early training. (C) Maybe his parents were too strict with him, or didn't try to see his point of view, or didn't train him to meet the problems he'd come up against when he grew up.
>
> It could be that he was a spoiled kid. (C) His home training when he was young, lack of discipline.

> He probably didn't have very many responsibilities when he was younger. (C) His parents did his thinking for him and gave him everything he wanted.

While psychiatrists might disagree about the relevance of these particular psychodynamics to the emergence of paranoid trends, their use in explaining "Frank Jones" represented an orientation to human behavior generally in line with technical psychological thinking, even when the details were not. In contrast, however, the causal significance of interpersonal relations was more frequently formulated in quite a different way.

This remaining interpersonal approach, which was used with about the same frequency as were organic determinants or environmental stresses, was a variation of conditioning or learning theory which essentially required that the manifest content of behavior necessarily be related to causes of the same manifest content. Specifically, in the case of "Frank Jones," who had been described in terms of unusual suspiciousness, the causes were sought in suspicion-creating experiences, and the experiences selected were always of a kind that any person having the same experience could be expected to respond to with some degree of suspicion or distrust. In other words, for the people who used what we have called "direct, equivalent conditioning," suspicion was the automatic, inevitable outcome of experiences which were culturally--if not universally--defined as suspicion-provoking.

In its simplest and least-used form, "Frank Jones" was the product of parents who had themselves been unusually suspicious and distrustful of others, and he took over their patterns by imitation or instruction. For instance, "There is nothing wrong with the man, mentally or physically. I'd just think he was trained this way. He was probably raised in a backward home and just doesn't know any better." Much more usually, however, "Frank Jones" had had unfortunate dealings with other people. In this version, "Frank Jones" was viewed as having been, at some time in his life, the

victim of persecution, injustice, or mistreatment.[9] A wealth of concrete

[9]The following categories of interpersonal relationships, shown in Table 22, are classified as "direct, equivalent conditioning" for "Frank Jones": "Others have slighted, rejected, ostracized him"; "Others have ridiculed, belittled, humiliated him"; "Others have objectively discriminated against him, treated him invidiously"; "Others have objectively betrayed his trust, confidence"; "Others have acted unfairly, unjustly, inconsistently toward him"; "Others have acted damagingly, hostilely, distrustfully, suspiciously, toward him, other and unspecified." Three additional causal categories are classified as conditioning for all persons, as indicated in Table 22. The remaining interpersonal categories in that table are classified as "environmental circumstances," whenever they occurred in adult life, and as "psychodynamics," whenever they were not clearly factors in adult life.

detail was called upon to illustrate the central point: his wife had committed adultery with his best friend, a business partner had defrauded him, he had been tricked by a confidence man, his childhood playmates had made him the butt of their jokes and pranks, his parents or other important people had demonstrated their hostility toward him or their lack of trust in him. For instance:

> Someone has to do something against him in order to have him believe that.
>
> Something might have happened that made him dwell on it, from his past life, like someone working against him.
>
> Probably some past experience. (C) He might have been cheated or given a raw deal by someone he trusted.
>
> It isn't always exactly a mental case; sometimes, somebody you've trusted has failed you.
>
> Maybe he <u>did</u> catch his wife doing something wrong and knows he can't trust her.
>
> Maybe once he was attacked by some hoodlums, and now he thinks--you know--that others are going to do the same.
>
> (P) He probably believed in someone who let him down, and now he thinks everyone is like that.
>
> He could be suspicious because of business dealings. (C) A bad deal in a business way might make him even distrust his wife.

> Maybe when he was a kid, he was a skinny little boy. All the kids could have taken advantage of him, taken his toys away, played tricks on him, teased him. That affected his mind. He expects everyone to treat him like that.
>
> His parents might not have treated him so he could trust them and when he grew up he couldn't trust anybody. Or maybe something happened to his job or his married life to cause him to take that attitude.

Whatever the concrete details chosen, the underlying theme of this group of explanations was that there was a time in "Frank Jones'" life when people really were against him and he was quite justified in distrusting them and suspecting their intentions toward him. Following this experience, he had drawn the moral well or too well and, by generalization or over-generalization from it, arrived at his orientation toward the world. It is noteworthy that, in contrast to technical theories of conditioned learning, this popular version typically relied on a single conditioning experience rather than a series of consistent or reinforcing experiences, and this unique experience could equally well have occurred at any time in "Frank Jones'" life. (Of the people who used the conditioning approach, roughly a fourth located the experience in his childhood, a fourth in his adult life, a fourth in either or both periods, and a fourth made no clear time reference.)

The question of why this single, adult experience should have had such an overwhelming effect in determining "Frank Jones'" outlook was not often directly dealt with. It was, perhaps, sometimes answered by implication in the frequent choice of agents of betrayal or injury who were defined as of unusual emotional importance to him--"someone dear to him," "someone he trusted," "someone he believed in," "his closest friend," "his wife,"--where, it may be presumed, the traumatic effect of the hostile act was in direct proportion to his prior confidence in the actor. As one person summed up his explanation of the conditioning process: "So,

now he's become suspicious of everybody. After all, if you can't trust your wife, who can you trust?".

Aside from this suggestion of the depth of the trauma, however, the conditioning explanation generally stopped at this point, leaving the strong implication that "Jones'" paranoid tendencies were the inevitable outcome of experiences which would have evoked the same reaction in anyone undergoing them. From this point of view, "Jones'" emotional reaction was a reasonable response to the conditioning circumstances, so it is not surprising that explanations of this order were associated with viewing "Frank Jones" as a personality molded by his experiences. In fact, this approach made it difficult to classify behavior which so plausibly and naturally arose from experience as mental illness: 68 per cent of those who used only the conditioning explanation regarded "Frank Jones" as mentally-ill, in contrast with 77 per cent of those who used both conditioning and other causal explanations and 78 per cent of those who used only other types of causal explanation. There was, obviously, a tendency to define the outcome of conditioning as normal but, just as obviously, it was not so dominant as to obliterate perception of the psychotic quality of "Jones'" behavior.

The kind of paradox created by explaining "Jones'" reactions as inevitable, natural, universal responses derived from experiences outside his control and then classifying his responses--defined as normal for those experiences --as mental illness was not often explicitly resolved. Four-fifths of the people who employed the conditioning mechanism took it no further, but the remaining fifth made an attempt to define "Jones'" responses as deviant. For these people, the conditioning experience was still essential, and "Jones'" initial, immediate tendency to respond with suspicion and distrust was the expected outcome of the experience. "Jones,"

however, deviated from the average run of human beings in carrying his reaction further or in persisting in it longer: he had thought about his genuine injury so much or so long, or brooded over it until it "preyed on his mind." In short, one unfortunate experience had been exaggerated out of all proportion until the natural suspicion emerging from it, which would otherwise gradually have worn off or been limited in its application, became a dominant orientation toward everyone. "Jones'" failure to evaluate his experience correctly, his tendency toward obsessive preoccupation with his grievances, and the attendant lack of self-control or self-indulgence implicit in "letting it prey on his mind," or "being too weak to stop brooding over it" thus became the crucially-determining causal elements, and these were, almost always, themselves left unexplained, attributed to innate character or regarded as conscious, free choices. Where these were added to the conditioning experience, "Jones" was classified as mentally-ill about as frequently as he was when other causal approaches were used: 76 per cent of those who qualified the conditioning process in this way regarded him as mentally-ill, in comparison with 65 per cent of those who employed only the "pure" conditioning process.

This discussion of popular interpretations of paranoid trends, as exemplified by "Frank Jones," may, perhaps, best be summed up by examining more directly how the elements so far discussed--the psychological terms in which he was perceived and the ways in which he was accounted for--entered in to determining whether or not he was mentally-ill. For the most part, the question of whether or not "Frank Jones" was mentally-ill was resolved in terms of a judgment of the degree of deviancy of the psychological trends perceived to be operating in him; that is, the question was primarily one of how deviant his perceptions of reality and his responses to it appeared to be. (See Table 27.) For example, over a fourth of those who regarded him

as mentally-ill explained their judgments with comments about the deviancy of his emotional outlook or, more particularly, the deviancy implicit in his extreme suspiciousness:

> He is upset and has funny ideas about life around him.[10]

---

[10] These are answers to the question, "Why do you say that he has a mental illness?".

> A normal person doesn't have an inferiority complex.
>
> By his actions: it isn't normal to think everybody's wrong.
>
> On account of he thought everybody was against him.
>
> A normal person won't be inclined to be suspicious of people.
>
> He don't trust anybody and is all the time watching people.

An equally large group stressed the deviancy of the irrational, uncontrolled quality of his behavior, emphasizing, especially, his resort to physical violence as proof of mental illness. For instance:

> He is too violent for not being insane.
>
> Because he beat up two men who didn't even know him and threatened to kill his wife.
>
> His actions. The beating of his wife shows his mind is off.
>
> Because he's weak minded and breaks down, and he can't help it.
>
> He either can't or won't control it. He worries about things that never happen and lets them get too much control of his mind.
>
> Anyone with a normal mind doesn't think people are following him, if they're not.
>
> Because he acts and talks crazy, sounds crazy. Why, no one would go around and do those things if they had good sense.

Or, in even more general terms, the third largest group of reasons simply

underscored abnormality and deviancy:

> He isn't acting normal.
>
> A normal person isn't going to act like that, so something's wrong with his mind.
>
> This isn't normal behavior.

On the other hand, those who did not regard him as mentally-ill also used considerations deriving from the intrinsic character of his reactions as their most frequent reasons for not doing so, although such reasons did not bulk as large as they did on the other side of the issue. (See Table 28.) But, about a third indicated, in one way or another, that they did not regard his behavior as sufficiently deviant or deviant in the crucial respects needed to call it mental illness. These people were roughly divided between those who saw nothing wrong with his behavior and did not amplify on this judgment and those who mentioned such characteristics as the conformity of his behavior to that of other people's, his ability to function in a fairly normal fashion, or the absence or relatively small degree of irrationality or uncontrolled behavior. Thus, they commented:

> Everyone has certain quirks that are more extreme than others, and he would not be considered sick by doctors.
>
> Lots of people get ideas about such things and do a lot of foolish things without being mentally-ill.
>
> They don't say anything about the way he looks or if he can keep his balance--can he eat by himself or go to the bathroom. (C) That is what I mean by mental.
>
> To me, if he was mentally sick, he would do more drastic things.
>
> Because if he would be crazy somebody would have sent him to an asylum or something. They don't let crazy people go around.
>
> He's probably just as smart as anyone else.
>
> There isn't anything wrong with his brain. (C) He has brains enough to know that somebody cheated him, so he has able thoughts.

It hasn't gone far enough yet.

Obviously, then, the same psychological tendencies could be viewed either as deviant enough to be called mental illness or as not deviant enough to qualify for this label. It is just because psychological description was not, by itself, logically sufficient to determine its classification that it turns out, at one and the same time, that perceptions of the quality of "Jones'" reactions were not (as indicated earlier) highly related to judgments of whether or not he was mentally-ill, even though these same perceptions were used as the most relevant consideration in making the judgment. In other words, what is beginning to emerge here is some indication of the additional conditions to be met before behavior descriptively corresponding to popular ideas of mental illness was actually classified as mental illness.

Since this is a large question, which can best be approached on the basis of all six examples, rather than in terms of "Frank Jones" alone, systematic consideration of it will be postponed until the other five human problems have been presented. But, it is possible to see, in "Frank Jones'" story, the beginnings of an answer. As has already been demonstrated, an approach to the explanation of "Frank Jones" in terms of an extreme conditioning theory militated against seeing him as mentally-ill, and causal considerations of this kind were the second line of reasoning that entered into the final disposition of "Jones." Roughly 12 per cent of those who did not view him as mentally-ill took this position because they exempted behavior which had resulted from conditioning or from other "real" external causes from mental illness, while four per cent reasoned the same way about behavior which they had attributed to organic causes. For instance:

> It's all his parents' fault. Nobody ever treated him good, so now he's suspicious of the whole crowd.
>
> Because if people had treated him right, he'd be all right.

Circumstances could have caused it. If people have treated him as an outcast.

He has an inferiority complex, not mental illness. (C) An inferiority complex is something that is built up by circumstances. With mental illness, it's not circumstances; you suddenly snap. Complexes can last for years.

He's just worried. A man under financial strain doesn't have a mental illness; he's just naturally suspicious of people.

Because maybe the reason he acts that way is because he is in debt, and, if he were out of debt, he wouldn't act that way. He'd clear up as soon as the problem that is worrying him is met.

Because he sounds like a person who has a physical condition. He's just the irritable type caused from a sickness.

It's not necessarily mental. It could be a physical condition, like being hard of hearing, that makes him suspicious.

Quite consistently with these results, nine percent of those who regarded "Frank Jones" as mentally-ill did so because they could not adduce "real" (physical or environmental) causes for his behavior. They had, therefore, to conclude that his beliefs were "all in his mind" and that his behavior proceeded from his beliefs. Similarly, eight per cent felt that they could not account for his behavior except by postulating mental illness as the underlying source of it. And, in the same direction, five per cent regarded him as mentally-ill because they postulated mental or emotional conflict, strain and fatigue as the causes of the behavior. Here are a few illustrations of this approach:

A doctor couldn't place his hand on it. It isn't visible, so it's mental.

Nothing physical would make him do that, so it has to be in his mind. (C) It's all in his head. His mind is sick, his body isn't affected.

Because if it wasn't, it would be a temporary situation. (C) Suppose he really were swindled by an individual, he wouldn't feel <u>everybody</u> was against him. This is in his mind; it didn't happen. There's no proof at all that any of those things he thinks have been done, and thinking is mental.

Unless a man has reason for suspicion there's something wrong with his brain.

He'd have to be mentally-ill, because I can't think of anything else that would make him act this way.

It must be something mentally wrong, because people don't threaten to kill and do harm to people without <u>some</u> reason.

He wouldn't be like that if he wasn't, would he? You have to be off to go around beating up people.

So many things are working on his mind. (C) When you force extra strain on any part of the body, it causes illness. His brooding has caused his mind to be ill.

He worries so much, it affects his mind. (C) It's worry that drives people crazy. Maybe it's his sin on his mind that is making him afraid and violent.

A somewhat different kind of causal consideration was introduced by six per cent of those who thought "Jones" was not mentally-ill. These people felt that his behavior was within his conscious control and, therefore, indicative of a faulty character, who was responsible for his own difficulties and could or should correct them himself. In contrast, two per cent of those who classified him as mentally-ill did so because they regarded exactly this kind of moral weakness as the essence of mental illness. Here are the contrasting viewpoints:

<u>Not mental illness:</u> All his troubles are of his own making.

No, it's the devil! (C) It's something wrong he's done, and it's got nothing to do with mental illness. He needs to join the church and quit his evil ways.

He's just mean and evil and doesn't want to be any different.

<u>Mental illness:</u> He won't control himself. He worries about things that never happened and lets them get too much control of his mind.

He's weak enough to let his troubles and the little conditions he's working under get on his nerves.

Because he's let his mind go the wrong way in place of thinking right.

Considerations of the kind of treatment or counteraction needed and the ease with which "Jones'" abnormal behavior might be corrected also sometimes led to the conclusion that he was not mentally-ill, although the reverse of these arguments was seldom used in deciding he was mentally-ill. People in this group tended to feel that his behavior was temporary, that he would recover easily and that such measures as might be taken by his family and friends would suffice. Given these assumptions, they could not regard his behavior as serious enough to justify the name for mental illness:

> He's just nervous and not serious. (C) With rest he can improve quickly.
>
> He could get over it if someone would talk to him about it.
>
> Because that can be easily corrected. (C) If he can be made to face facts--that he is no better than anyone else.
>
> Because, with the proper psychiatric aid, he might be able to overcome this.
>
> It seems to me a case like that could be straightened out.

The final, and perhaps the most tantalizing, group of reasons for deciding that "Frank Jones" was not mentally-ill was offered by one person in ten and consisted simply of asserting that it was something else,--usually of a psychological or emotional nature--rather than mental illness, without any clarification of the basis on which the distinction rested. Since it was not clear whether these people meant that their counterterm was a less seriously deviant condition, or that it lacked some of the intrinsic qualities of mental illness, or had different causes or outcomes, little else can be said about their point-of-view. For instance:

> It's more a suspicious disposition than mental.
>
> I don't think it's so much a mental illness as it is a wrong application of talent.
>
> No, it's a guilty conscience.

> Because it seems to be just brought about from having an inferiority complex.
>
> He's just plain mean, nothing mental about him.

Quite similar considerations of the character of the symptoms and the urgency, nature and ease of treatment were at the basis of decisions about the seriousness of the mental illness "Frank Jones" was assumed to have. As presented in Table 29, over two-thirds of those who took a serious view of his condition were thinking of the threat of physical violence he posed to others around him. They said things like:

> Because of the violent character of it. He may injure or kill someone with no reason for it.[11]

---

[11] These answers are in response to the question: "Why do you say it is serious?"

> It can develop much worse. He may even become a dangerous person and do real harm to people.
>
> Because he'll kill someone, sure as fate, someday.

Occasionally, other characteristics of his illness were cited, such as the dangers inherent to his own life in the illness, the serious nature of psychosis and some of its symptoms, like irrationality and loss of contact with reality. More frequently, however, "Jones'" symptoms were regarded as serious because people saw an urgent need for treatment or control of his condition and felt it would become still more serious or even incurable, in the absence of immediate treatment:

> Absolutely! People like this should go in a sanitarium and get cured.
>
> It never stands still and will get worse if not attended to. (C) He must get a connection with God.
>
> It will be serious if it isn't taken care of. (C) He should see a doctor.
>
> Anything in the way of sickness should be taken seriously. (C) They can come out of it, but if it wasn't caught in time and treated, if let go without treatment, it may be too late.
>
> He'll get worse if something isn't done.

Those who felt his illness was not serious, on the other hand, tended to reverse this emphasis. (See Table 30.) For them, the intrinsic character of his symptoms was seldom touched on, although eight per cent denied that he was a physical danger to others and about as many felt that he was not so very irrational, unable to function or deviant. They commented:

> These things aren't too serious, like thinking people are following him and things like that. (C) He can't hurt anybody by doing that.
>
> No, because they don't get into trouble other than arguments.
>
> He's not bad enough to send away. (C) He can work.
>
> He'd do worse things than that if he would have a serious mental illness.

In contrast, the large majority of those who did not regard "Jones'" illness as serious were stressing the curability of his condition and the simplicity of the means by which it could be cured. Some nine per cent felt he could cure himself; an equal number thought his family or friends could do so; six per cent thought any physician could handle him; 13 per cent regarded him as a very simple type of case for psychiatry; and many more stressed only the sheer curability of his condition. For instance:

> It couldn't be serious. Sometimes, people are only putting things on. If he eases up, he'll come around.
>
> They bring it on themselves and they can get over it themselves.
>
> He'll feel better afterwards, after he fixes whatever he's done and has a clear conscience again.
>
> Because, if he could be taught to trust people and rest and think things over, he would see how wrong he was.
>
> It could be corrected. (C) You'd have to get his confidence and have him get whatever's bothering him off his mind.
>
> If he'd let his family help him; he'd get better.
>
> I've heard of people like that who got cured by going to a doctor. He can go and have a treatment.

He could be cured easily. (C) By going to a doctor and letting him check him over and see what's wrong and taking the doctor's advice. (C) It could be any doctor, but I guess a psychiatrist would be better.

I think it's curable. I think he needs a psychiatrist's advice and some level-headed companions.

The word, serious, to me seems about the end. I think if they'd take him now to a doctor, or a psychologist could bring him out of it.

A couple of visits to a good psychiatrist who could find the cause of his hatreds and suspicions could clear it up.

A psychiatrist could straighten him out easily.

It can be corrected.

He could be helped and even cured.

As a kind of final summary of the whole question of "Frank Jones," we may ask what kind of an action problem he presented to people, especially when they did not view him as mentally-ill.[12] As shown in Table 31, two

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[12]This action-problem classification is developed from any statements about indicated countermeasures people made, and statements from which a reasonable inference could be made. Thus, if a person said he was physically-ill, "Jones'" is classed as a physical problem, even though this particular respondent did not refer directly to treatment.

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per cent of those who did not regard him as mentally-ill did regard him as a psychiatric problem, and another six per cent had classed him as nervously or emotionally ill without indicating the nature of the treatment problem. Certainly for the first group, if not for the latter, the distinction between mental illness and their view of "Frank Jones" was largely a semantic one, where only a difference of terminology was primarily involved in their failure to perceive mental illness in "Frank Jones." These were, however, not the major viewpoints among people who did not call him mentally-ill. Instead, 20 per cent regarded him as essentially a moral problem who should use self-help to correct his character flaws; 15 per cent saw him as a victim of

external circumstances whose behavior would change if his situation were remedied; eight per cent regarded him as either a medical or a physical problem to be resolved by medical treatment, rest and the like: and three percent felt he was the kind of psychological problem to be met by skill in interpersonal dealings with him. For 22 per cent he was a personality type about which they felt there was "something wrong," but whom they had neither morally condemned nor addressed themselves to correcting. And 19 per cent saw him as completely non-problematical: it was too trivial a situation to call for action, his behavior was within the range of normal variation, and so on.

It is, thus, clear that most of the people who did not perceive mental illness in "Frank Jones'" behavior either saw no problem about him or found him a problem of an other than psychiatric order. The fact is, however, that many of these same people did not always, or even usually, consider mental illness a psychiatric problem, either. Full documentation of this assertion requires a comparison of these problem-classifications of "Jones" with what the same people said about the nature of the problem in other examples, but it may be observed, parenthetically, that, while psychiatric treatment was the single approach most often recommended by people who regarded "Jones" as mentally-ill, they mentioned non-psychiatric treatment approaches more frequently. (Table 32.) When the stories of the other five "persons" have been presented, it will be possible to deal more fully with this question of the kind of problems personality--whether or not mentally-ill--posed for the American public.

The Story of "Betty Smith"

In contrast to "Frank Jones'" violent, paranoid behavior, the psychotic syndrome illustrated by "Betty Smith" was one where she appeared to be, on the surface, at least, quiet, tractable and bothering no one. Given this image, two-thirds of the public did not regard her as mentally-ill, and less than half of those who did see her as mentally-ill, classified her illness as serious. (See Tables 12 and 15.) Where differential diagnoses were available, she was, in fact more often regarded as non-psychotic than as incipiently or already psychotic.

For 95 per cent of those who did not see "Betty Smith" as mentally-ill, she was regarded as a typical instance of conditioning, temperament or personality. Only rarely were alternative classifications, like physical illness or reasonable reaction to current situation, called upon in explaining her, and the kind of personality that she represented was rarely discussed in disapproving terms. (Table 16.) As with "Jones," "Betty" was usually regarded as a personality type who was not condemned, whether people felt there was or was not something wrong with her, although she was somewhat less frequently seen in these terms by those who felt something was wrong. (Table 17.)

In the course of arriving at their classifications of "Betty Smith," people had formulated the essentials of her personality in two rather contrasting ways, as shown in Tables 19-21. Most frequently she was characterized as she had been presented--as a withdrawn, introverted, asocial person--a person who feared or disliked people and preferred solitude. Some 29 per cent of the public described her in some such terms as:

> She just doesn't see the necessity of associating with people.
>
> She just likes to stay by herself.
>
> There are lots of people in the world who don't take no interest in other people. They just don't like to be with other people.

> She is just satisfied by herself, the type that doesn't need people to be happy.
>
> In some cases, it's not shyness; they just don't like to be around anybody.

On the other hand, about a fifth of the public perceived her in terms of shyness, timidity, bashfulness or "backwardness," the difference being that they thought of her as avoiding people because she lacked social poise rather than because she lacked motivation. Such people made comments like:

> (P) I think she's just bashful by nature. (C) She probably wants to get out and be with people, but she's scared to because she's bashful.
>
> There are people like that. My husband is one. You might call them backward, but they might just be shy. (P) I think it's just her nature. My husband is timid, not outspoken.
>
> She's just afraid to venture out and do things or talk, and that's why I'd say she's just backward, needs to gain confidence in herself and learn how to talk to people.
>
> It's shyness, or, maybe, embarrassment of some kind, like being afraid she'll say or do the wrong thing.

The characterization of "Betty Smith" as asocial was somewhat more likely to go along with seeing her as mentally-ill, while the shy, self-conscious version was most typically used in the context of seeing nothing problematical in her behavior. Either account of her social difficulties was frequently accompanied by references to her having an inferiority complex, feelings of insecurity, lack of self-confidence or self-consciousness. One-fourth of the public used such psychological descriptions, although the group who regarded her as non-problematical was less likely to do so and most frequently treated her shyness and self-consciousness as one simple trait.

The three basic personality patterns--the withdrawn, asocial; the inferior, insecure; and the shy, self-conscious--were occasionally

elaborated in terms of further psychological details. Thus, about ten per cent added that she feared or disliked people, four per cent limited the fear or dislike to men, and still fewer thought she feared or disliked the idea of sex. Similarly, about five per cent called her apathetic, indifferent and lacking interest in activities as well as in people; four per cent regarded her as a pervasively anxious personality, and four per cent viewed her lack of sociability as an attempt to conceal herself or her shortcomings from others. Here is an example of a more elaborated comment:

> (S) I would think one thing. She's afraid of life either because she knows nothing of life, or she has a wrong picture. It's a type of neurosis you see more in girls than men, and I think it's a sex impulse, where they fear sex and that side of life. She's afraid of herself in all things; actually embarrassed about herself, and I think it must revolve around the sex impulse and horror of life and the sex life.

Aside from these essentially reinforcing themes, no other single psychological trend was mentioned by as many as four per cent, and only one person in ten described "Betty Smith" in terms that did not include reference to these basic tendencies.

About one-fifth of the public terminated their discussion of "Betty Smith" at this point: four per cent were unable to discuss her at all, six per cent described psychological trends but did not know how to account for their development, four per cent attributed ultimate causal significance to these psychological tendencies, and eight per cent simply never touched on the question of causes. (See Table 18.) Almost all the people who talked in terms of the causal significance of personality--both the four per cent who did so exclusively and the four per cent who did so along with other approaches to causation--were thinking of innate personality or termperamental factors: it was simply her innate "nature"

to be asocial, quiet or shy. As with "Frank Jones," both the tendency to cut off discussion of "Betty Smith" without leaving the psychological level and the tendency to explain personality by innate nature occurred disproportionately among people who saw nothing wrong with her.

Most causal explanations of "Betty Smith" concentrated either on direct, equivalent conditioning or on other aspects of the psychodynamics of her childhood. Forty-nine per cent of the public--a majority of those who offered classifiable explanations--talked in terms of conditioning, while 24 per cent discussed other aspects of her childhood relationships. In contrast to explanations of "Frank Jones," only 10 per cent used organic lines of explanation, and only 17 per cent attributed her behavior to external circumstances. In part, this relatively low use of organic and environmental factors in explaining "Betty Smith" was consistent with the fact that she was not usually regarded as mentally-ill. For, as indicated in connection with "Frank Jones," these two groups of causal factors were usually introduced as generic causes of mental illness, once mental illness had been singled out as the significant category to be accounted for. With "Betty Smith," organic factors and environmental stresses were also employed with greater frequency by those who regarded her as mentally-ill, but they still were not introduced as explanations of her mental illness as frequently as they were in explanation of "Jones'" illness. Instead, the great majority, whether they viewed her as mentally-ill, problematical or a normal personality, concentrated on accounting for the relatively unique features of her behavior. (See Tables 22-24.)

Since the organic and environmental causes of "Betty Smith's" behavior differed only in details from those adduced for "Jones'," we can dismiss them quickly to concentrate on the unique features of this example. As shown in Table 22, organic factors were, for the most part, divided among

inherited or congenital mental illness, injuries to or diseases and vague organic anomalies of the brain or nervous system, diffuse effects of poor physical constitution and glandular ("female") disorders. Of these, only the last had little bearing on the problems of "Frank Jones." Here are some typical comments:

> (P) She probably never had any push to herself to want to go out and meet people or go to work. (C) She is probably nervous and didn't have the nerve to do these things. (C) Probably a mental sickness from the time she was born.
>
> (P) It's the lack of something in the blood that makes her mind asleep. (C) A sickness in the blood.
>
> (P) She could have had some sort of operation to remove all her sex organs, and that made her abnormal.
>
> (P) It could be that female sickness or something of that sort could be holding her back. It causes her health to be poor or not as it should be.

The external stresses affecting "Betty Smith" were roughly divided between conflicts in interpersonal relationships or difficulties with her family and cultural and physical influences which placed her at a disadvantage with respect to others. Since she had been presented as a young, unmarried, dependent girl, living at home, the "money troubles, job troubles" theme, so frequently mentioned in connection with "Frank Jones," was seldom, if ever referred to. Instead, people said:

> Something happened in her life that she is brooding over. (C) There is something in her mind. (C) It's usually an incident in one's life. (C) Like an unhappy love affair or a family tragedy.
>
> I've known of people who lost their lover, and they seemed to lose interest in life.
>
> Sometimes lack of education might cause it. I think you find that in the South more than here. (C) Any child that doesn't go to school and just sits home would naturally be that way.
>
> She's not used to being around people. (C) She may have been brought up in the country, on a farm. Generally, there aren't many people around, on a farm.

> Probably she is real ugly or is real big and fat or has a physical defect, and this causes her to kind of withdraw from everyone.
>
> She might have a sister who is prettier or more popular.
>
> Maybe she was disappointed in some way or other, and it affected her that way. (C) A lot of cases where a girl wants to be a nurse, for instance, or follow a profession, and her folks don't want her to.
>
> I'd say she's unsatisfied. (C) Her people, her homelife. (C) A dirty house, a father who isn't neat, probably loud, uneducated people that she's ashamed of, so that she would keep away from them and would rather be alone. There could be a clothes problem, too. Maybe she hasn't nice clothes to wear: your appearance has a lot to do with it. If you haven't decent clothes and need a permanent, it takes all the good out of you.

As these illustrative comments make clear, "environmental circumstances" for "Betty Smith" contained both general stresses which were viewed as provoking an abnormal condition and handicapping life conditions which were viewed as likely to produce social ineptness, embarrassment and withdrawal. In this latter group were classified a number of "quasi-physical" factors--like fatness, ugliness, etc.--which, though usually cited as if they directly caused her reactions, could not logically be conceived of as a strictly organic process of which her behavior was the outcome. Similar "quasi-physical" factors had been mentioned in connection with "Frank Jones" also, but they did not loom as large among the circumstances of existence in which he found himself as they did for "Betty Smith."

With this "stimulus-response" scheme, in which "Betty Smith's" presumed unfortunate physiology or physiognomy was viewed as inevitably eventuating in an inferiority complex, self-consciousness or withdrawal, the causal discussion of "Betty Smith" has reached the limits of what has been termed "direct, equivalent conditioning." Because we did not wish to overestimate the prevalence of this popular version of conditioning,

these "quasi-physical" factors have been omitted from conditioning, as have essentially similar culturally-handicapping conditions--like lack of wardrobe, poverty and regional differences in educational standards.

The direct conditioning approach instead, was limited to explanations in which "Betty Smith's" lack of social participation and/or fear of people were explained by her lack of social participation and/or people's alienating actions.[12] Two main emphases ran through these causal ex-

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[12] For "Betty Smith," the following causal categories, shown in Table 22 under "interpersonal relationships," are classified as "direct, equivalent conditioning": "Others failed to teach sociability, social conduct"; "Others failed to teach reasonable attitudes toward sex"; "Others failed to encourage contacts with people"; "Others slighted, rejected, ostracized"; "Others ridiculed, belittled, humiliated"; "Others barred, restricted person from contacts with people"; "Others discriminated against person"; "Others sexually injured person"; "Others objectively betrayed person's trust, confidence"; "Others acted unfairly, unjustly, inconsistently toward person"; "Others frightened person"; "Others acted damagingly, hostilely, distrustfully toward person"; "Relationships with others are lacking, absent." All other interpersonal categories are classified for "Betty Smith" as "environment, circumstances," when clearly in the present or her adult life, and as "psychodynamic relationships," when not clearly adult circumstances.

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planations, both of which agreed that she had not learned to be sociable, to like and feel comfortable with people. The first of these, which was rather infrequently used, regarded "Betty" as, essentially, conditioned by the absence of positive conditioning. In this version, it was either assumed that everyone had to be taught to be sociable and that "Betty Smith's" parents had failed to teach her to like people and to get along with them, or else "Betty" was regarded as having been, innately, a shyer than average temperament, whose parents neglected to take steps to encourage social relationships or "push" her into social relationships. For instance:

> Because she hasn't been taken out around the public. She probably had no kind of schooling. (C) Just because she didn't have nobody to teach her any better. (C) Maybe her mother didn't know any better.
>
> Maybe she hasn't been taught how to approach people.
>
> In their early life, they never was put in contact with people, and they're just scared when they grow up.
>
> Probably her family just raised her that way and never showed her how to go out with people.
>
> Probably from childhood environment she became shy around strangers, and then, as she grew older, she became more shy. (C) Probably her parents' fault for not training her to be friendly, letting her go without making an effort to overcome her shyness.
>
> Her mother hasn't made her mix with other people. She should have been pushed out more in the company of others.

Much more frequently the conditioning argument assumed that she had been positively taught to avoid social relationships: either her parents had restricted her associations with people until she became accustomed to the isolation, or they had taught her to fear people and, especially, men and sex, or her original social experiences with others had taught her to avoid them in the future. Thus, 16 per cent said "Betty's" contacts with people had been restricted or prohibited, and one person in ten among this group was so literal in his approach to conditioning as to explain her current pattern of leaving the room when people arrived by reference to her parents' having once habitually required her to leave the room whenever company was present. Some typical ways of putting this line of reasoning were:

> She may not have been let to have friends when she was younger.
>
> She may have been neglected in her childhood. (C) They didn't leave her mingle with children. (C) I think her parents are responsible for her actions. (C) She was kept alone all the time.

> Probably her family just raised her that way and never showed her how to go out with people, or maybe she didn't get a chance to get out. (C) Some mothers are hard on their children, and the children get set back and that breaks their courage. (C) Probably, when she did want to go out, her mother didn't want her to, and she just got set back.
>
> It might have been her early training. (C) Her parents might have made her keep away from people.
>
> I think her parents didn't understand her. (C) Probably they kept her in too much. They wouldn't let her go out with people her own age. It's not good to be kept too close, and it's warped her mind, and now she's afraid. Being kept away from people so much, she's afraid of them.
>
> Her parents probably did the same thing. (C) They probably made her go into the back room, while they had their company.

In a related fashion, seven per cent referred to direct teaching of fear or avoidance of people and, particularly, of sex:

> She was probably told that nice young girls were reserved and didn't talk much or associate with people.
>
> Her mother could have made her afraid of children by telling her they might teach her bad things.
>
> Maybe she doesn't date boys of her own age, because she knows of other girls who told her something happened to them.
>
> It must have been in her early life. (C) Maybe she was raised by an "old maid" and that gave her funny ideas. You know, they're queer, especially about men. (C) I think it's what this "old maid" taught her: that men would want to play around with her, maybe even "do her wrong," but they wouldn't marry her.

A final 18 per cent talked in terms of rebuffs, rejections, and injuries in social relations which had taught "Betty Smith" to dislike and be wary of people. Occasionally, these negatively conditioning experiences were linked to the girl's own qualities--people responded to her negatively because of her appearance, talents or personality, but, in five out of six cases, the hostile responses of others to "Betty" were not, themselves, accounted for:

Maybe the neighborhood kids picked on her or wouldn't play with her when she was little.

Maybe she isn't popular and stays away from people so she won't be hurt.

Maybe she is very homely and never had any friends.

She may have been ridiculed in groups or in school.

Maybe she didn't dress well and someone made fun of her, or maybe it was halitosis.

The wrong kind of upbringing. (C) They may have told them they are not good in anything, and they lose self-confidence.

Did her parents nag her? If they did, they maybe stuck fear into her.

It could be caused by childhood. (C) Scared by people who came to the house or was in the family. (C) An awful fright of some kind, so she's awfully afraid of all people now.

I don't know, she may have been frightened as a child. (C) Maybe burglars broke in the house, and it has always preyed on her mind, or something like that. I don't know, she's scared, and so she stays clear of everyone.

Aside from these conditioning experiences, other relationships of her childhood were the next most frequently used factors in explaining "Betty Smith's" current behavior. But, just as environmental circumstances merged into conditioning in this case, the dividing line between conditioning and these other psychodynamic relationships was far less distinct for "Betty" than it was for "Frank Jones." That is, the major subcategories of "psychodynamics" were parental overindulgence and overprotection, used by about five per cent; and parental over-repressiveness, used by about 11 per cent. Since these were also the usual motivational explanation of the presumed parental restriction on social relationships, it was not always possible to know, definitively, whether the broader or narrower interpretation of parental domination was indicated. Discussions which did not clearly restrict these parental tendencies to the area of social activities were

classified as "psychodynamics," in order to avoid artificially inflating the popular tendency toward narrowly-defined conditioning theories. The upshot probably is that use of the psychodynamic category is overestimated for "Betty Smith," where it appears to have been used over twice as frequently as it was with "Frank Jones" and moved from being the least-frequently used causal explanation of "Frank Jones" to the second most frequent one for "Betty Smith." Here are some comments typical of those classified as psychodynamics:

> Perhaps her mother shielded her too much.
>
> She was overprotected as a child, which has given her a feeling of insecurity.
>
> It could come from early family life. (C) Some children have everything done and said for them when small, and, consequently, they don't attempt to talk or try to learn how to do things themselves.
>
> Probably the main reason is the way she was treated as a child and brought up. The parents are to blame for that mostly. (C) Oh, they probably have been too strict with her.
>
> Maybe when she was a child her parents kept putting her in the background and, when she said anything, they told her to be quiet. So she only did the things she had to and didn't try to make conversation.
>
> (S) She wasn't brought up right. (C) Her parents didn't give her the proper outlook on life. (C) They didn't teach her to look into the future.
>
> She may have felt as a child that she was never wanted. (C) Broken home and parents quarreling and lack of love may have caused her not to feel secure with anyone.

With the causal emphasis on conditioned socialization and psychodynamics, it is inevitable that discussion of "Betty Smith" dealt much more with childhood experiences than had been the case with "Frank Jones." As Table 25 makes clear, references to causes of "Betty Smith's" behavior located solely in her childhood outnumbered causes located in her adult life by about two to one. And, even when she was perceived as mentally-ill,

the most frequent causal explanation of her turned to her childhood, just as the specific causes adduced were not essentially different, whatever the degree and kind of problem seen in her behavior. (Table 26.)

As was indicated earlier, it was difficult for most people to subsume the kird of quiet, untroublesome behavior represented by "Betty Smith" under mental illness. The minority who did regard her as mentally-ill were thinking primarily of the deviancy of her behavior and, particularly, her withdrawal and lack of social relations, just as deviancy and, especially, deviant emotional response, was the usual reason for calling 'Frank Jones" mentally-ill. (Table 27.) Speaking of "Betty Smith," people commonly said:

> She's daydreaming all the time and wants to be alone, and I don't see many people like that.
>
> She's not really living. You can't live alone by yourself like that.
>
> A person in their right mind couldn't stand doing nothing all the time.
>
> It shows by not acting normal like other people.
>
> This is not a natural reaction for a girl of her age.

Although this kind of deviancy added up to mental illness for this minority, they were not inclined to regard it seriously either because they felt it was a condition that could be easily corrected or because it was an illness which appeared to pose no threat of harm to others. The minority who took a serious view of "Betty Smith's" illness did so because they valued fullfillment for the individual and, therefore, were concerned about anything which threatened to impair an individual life. So, they were likely to conclude that immediate treatment was needed to prevent wastage of human potentialities. (See Tables 29-30.) These two contrasting points of view often used almost the same ideas, but with a very different set of evaluations. Thus:

Not Serious: A person like this don't hurt nobody. They don't do any good, but they don't do any harm.

She's not hurting anyone but herself.

She don't threaten to kill nobody or nothing like that.

Serious: It's not serious for anyone else, but it is for herself. She's ruining her life, and, after her folks are gone, she'll be alone, and people will send her to a crazy house.

Especially for her. It affects her chances of enjoying life and may lead to insanity.

Because her life's useless to herself. She's not giving herself a chance to live like others and enjoy the good things of life.

Not Serious: She's so young, she'll probably overcome it. Something will happen to change her. (C) She'll get interested in something, some time, and forget to be like that.

All she needs to do is to force herself to get out with other people. If she'd start talking to people and going out, she'd learn to like them and would feel better. All she needs is willpower and to forget herself.

That could be very easily cleared up. (C) By her people talking to her and gradually taking her out places and getting her used to seeing people and talking to them.

I believe it could be cured. (C) Just take her out and let her get to running with other girls.

She just needs to be brought out of herself. A psychiatrist could probably make a normal person of her in a short time. ✓

Serious: She has to be helped before it's too late. (C) Psychiatric treatment is needed.

If these symptoms persist, she may be excluded from the world, living only in a world of her own, and that illness is the most difficult to overcome of any.

She needs help. (C) She'll have to go to a hospital, for a while at least.

For the majority, however, "Betty Smith" did not appear to be mentally-ill, and their conclusions about her were based on three main lines of reasoning, which were in many ways similar to the reasoning by which she

was regarded as mentally-ill, but not seriously. These points of view were: (1) that her behavior was either not very deviant, non-problematical or even desirable; (2) that her behavior was caused by events external to her so that others were viewed as responsible for her now engrained characteristics or her behavior was viewed as reasonable in her circumstances; (3) that her behavior could be unconditioned by the reverse of much the same process as had molded her to unsociability. (Table 28.) These ideas were typically expressed as:

Non-deviant: No, she acts all right; it's just that she doesn't care to see anybody. (C) Physically she seems to be O. K., and she doesn't harm anyone.

She's really not doing things much out of the ordinary.

Lots of us are that way; bashfulness isn't a mental illness. She is a quiet girl, and that is it.

I'm shy myself, and I'm O. K.

She's just quiet and has sort of funny ideas, but I just don't think they're bad enough to call mental illness.

That girl is just naturally quiet, I believe. (C) It may not be best for her, but I can't see anything wrong in it.

External: I don't hardly know how to answer that one. I've seen in picture shows where a girl has been kept away from people like that, but when she got out into the world and saw what people were really like, she snapped out of it entirely and was all right. I just think it is the way she has lived, not her mind.

Because it's shyness, and her parents caused her to be afraid of people so now she doesn't care for people.

She was just mishandled. With a different bringing up she could get out and have a good time and be all right.

Under the right circumstances she would be different. It is her environment that makes her what she is.

I think there's just some little quirk, but most of it must be due to her homelife.

It's just the way she is, due to something that happened in her early life.

Unconditioning: When she is put out to shift for herself, I think she will do better.

Her case could be overcome, if someone took an interest and tried to help her. (C) Just pay her some attention.

Her brain is O. K. She just needs to make friends and get more self-confidence. Her folks should treat her as an equal.

She could easily overcome it, if she had a new environment and new people around who would bring her out--some praise, compliments and jolly friends.

She could be told the truth about sex in the right way and brought out of her retirement. Her mother should take her into her confidence and talk things over with her.

It is implicit in these approaches to the question of "Betty Smith's" mental illness that, insofar as she was viewed as a problem separate from mental illness, she appeared as one to be resolved in terms of interpersonal relationships. Just over a third of those who felt that she was not mentally-ill but did require corrective action thought that a change in the circumstances--primarily, the attitudes and actions of crucial people in her life--which had produced her personality patterns would lead to their alteration. Quite similarly, an equally-large proportion felt that people who had not been initially involved in the formation of "Betty's" present personality could, through a careful psychological approach to her, undo the damage which others had caused. This last, "common-sense" psychological approach was also the largest single treatment recommendation of those who regarded her behavior as mental illness, and was advanced by half of those who mentioned any treatment procedure. (Tables 31-32.)

More often than this structuring of her as a problem of human relations, however, "Betty Smith" was regarded as posing no kind of problem at all. Slightly over half of those who did not see mental illness made clear that they saw no particular problems in her behavior, while another 17 per cent saw her as a personality with whom there was something wrong in the sense

that she was a little "odd" or "queer," but about whom they expressed little concern or need to change. This apparent complacency with seemly behavior, even when it was carried to the point of schizophrenic withdrawal, was sufficiently strong so that five per cent of those who called "Betty" mentally-ill went on to add that it was not the kind of mental illness which required that anything be done.

In the story of "Betty Smith," then, there is a shift from the violence of "Frank Jones," which usually connoted mental illness to the American public and called for psychiatric expertness more than any other approach, to behavior which did not appear to constitute a public menace or nuisance. With this shift, there was a great drop in recognition of either mental illness or of problematical behavior, and a tendency to feel that laymen could cope with such problems in "Betty Smith's" behavior as might require correction, even when the problem was formally labelled mental illness. With the next story--that of the alcoholic problems of "Bill Williams," attention returns, again, to behavior which approaches a public nuisance, and a different public orientation emerges.

The Story of "Bill Williams"

"Bill Williams" posed to the American public the problem of alcoholism and, in so doing, almost automatically brought considerations of social dependency, morality and the nature of personal responsibility and free will to a central position in popular interpretations of human behavior. As we have already seen, the popular tendency in approaching human behavior was to give more weight to manifestations in conduct--"Frank Jones'" violence or "Betty Smith's" withdrawal--than to their possible psychic implications. So, with "Bill Williams," the tendency was to regard his drinking, itself,

as the problem rather than to view it as an external symptom of emotional problems. Given this approach to "Williams" from the outside, his behavior could most easily be evaluated from the standpoint of the social consequences of his excessive drinking--an orientation which led more readily to moral judgment and condemnation of "Williams" than to concern with either diagnosis or etiology.

Thus, 29 per cent of the American public classified "Williams'" alcoholism as mental illness, as over against an identical proportion who felt that there was nothing wrong with him, and 42 per cent who thought something other than mental illness was wrong. (Table 12.) The large majority of those who did not subsume "Williams'" problems under mental illness followed the by-now-familiar pattern of thinking of him as a character or personality type, but, in contrast to the "individuals" who have so far been presented--or, for that matter, those yet to be introduced, --"Williams'" personality trends were most typically summed up in terms of disapproval and moral condemnation. As shown in Table 16, there were, roughly, three who spoke of "Williams" as a morally-defective character for every two who were not explicitly censorous of him. And the tendency to stigmatize "Williams" was even more marked among people who said there was "nothing wrong" with him: 56 per cent of them saw "Williams" as a character problem as over against 45 per cent of those who regarded him as having something other than mental illness wrong. (See Table 17.)

The alternatives to personality analysis--that circumstances alone drove "Williams" to drink or that he had an illness other than mental illness--were not frequently used, although illness was employed to categorize him more frequently than it was for any other "person" except the anxiety neurotic. As usual, references to illness were concentrated in

the section of the public who felt something was wrong with "Williams" and, in a majority of instances, represented an approach to illness that was seldom encountered, except in his case. "Williams" was rarely regarded as either emotionally or nervously ill; rather, to the extent that non-mental illness was perceived at all, he was either classified as physically ill or, more typically, as ambiguously ill. That is, the majority of people who talked of illness in connection with "Bill Williams" did so in a context which contrasted it with mental illness, but did not suggest physical illness. The illness they had in mind was, essentially, a moral one; they were thinking of an illness of the impulses or a disease of the will, but were trying to distinguish its ego-alien quality by calling it an illness rather than a character defect. While only one person in twenty introduced this concept of illness to explain "Bill Williams," it serves so well to epitomize the frequent conflict over what was "sick" and what "bad" in "Williams'" behavior that it cannot be overlooked. For instance:

> It's a disease; it's not mental. He's drinking because he craves it; he can't help it.
>
> He is really ill and not mentally ill, either. (C) It's a craving for liquor, only; that's his illness.
>
> Chronic alcoholism is a disease. (C) Once he got the taste of it, he can't stop consuming it.
>
> It's simply a desire for drink. That may be an illness in itself, but it's definitely not a mental illness.
>
> I think he's sick, but he's alcohol-sick. I've come to the conclusion myself that this alcohol business is just a plain disease. (C) I don't think alcoholics are mentally-ill. I think they're ill, all right, but I don't think they're mentally-ill. I just think it's lack of will-power.
>
> That's a disease of the will-power.

These comments set the stage for popular psychological discussion of "Williams," a step in interpretation which all but six per cent of the public undertook. (Table 18.) This discussion tended to concentrate

on the concrete element of "Williams'" excessive drinking, rather than on his personality more broadly conceived, and was, therefore, dominated by ways of characterizing excessive drinking. Thus, all of the most frequently used psychological categories referred directly to drinking and were roughly divided between three formulations of the underlying nature of an excessive drinker--"weak," 37 per cent; "driven," 14 per cent; and "deliberate," 12 percent--and two key words used to characterize the total significance of the drinking pattern--"alcoholism," 23 per cent; and "habit," 23 per cent. (Tables 19 and 20.) It is apparent that this kind of psychological depiction arose in the course of attempting to explain "Williams'" drinking and was, in fact, an essential part of these explanations. These interpretations can, therefore, best be understood in the context in which they were developed, and full presentation of them will be postponed until we can sketch in the main dimensions of popular approaches to alcoholism, as typified by "Bill Williams."

In some ways, the story of "Bill Williams" was more complex than the preceding examples, since it offered a greater variety of elements to be explained or levels on which to approach explanation. It was theoretically possible to talk about character formation, about the relation of character to a specific manifestation like drinking, about the role of external events in precipitating a given round of drinking, and so forth. Actually, explanations of "Bill Williams" were concentrated on accounting for why he currently drank excessively, with the main lines of explanation divided among predisposition, emotional needs or motivations, and the kinds of events which precipitated each cycle of drinking. Ninety-five per cent of the American public touched on this aspect of alcoholism, with 73 per cent limiting their discussion to the current mechanisms maintaining or

reactivating "Williams'" pattern of periodic drinking. The other 22 percent expanded their interpretations to include as well an account of how he happened to begin drinking, an approach which may be viewed as roughly dealing with "symptom choice" or why "Williams'" problems eventuated in excessive drinking rather than in some other manifestation. In addition to these two major orientations, one per cent spoke only of how the pattern of drinking had been acquired, one per cent accounted for the rest of his behavior by the fact that he was under the influence of alcohol,[13]

[13] It is noteworthy that eight per cent first answered the question of what caused "Williams'" behavior with an immediate assertion that he acted this way because he drank or because he was intoxicated. In almost all cases, interviewers then went on to ask why he drank. But the relatively high rate with which the one manifestation with physical consequences was called on to explain the rest of his behavior again indicates some characteristic features of popular logic.

one per cent characterized or described him without reference to the problem of drinking, and two per cent stated their inability to account for him. (See Table 33.)

The majority of interpretations of "Bill Williams" either explicitly included or implied an element of predisposition or impulse toward drinking, in order to account for his present tendency to turn toward alcohol.[14]

[14] The data about to be presented are based on coder ratings of the sense of each person's entire discussion of "Bill Williams." As such, they differ from the psychological data presented in Tables 19-21, in that the latter represent only explicit, clear-cut assertions of the psychological elements shown there and contain all such assertions regardless of their mutual consistency. These coder ratings, in contrast, include an inference as to the most likely meaning of the respondents' psychological interpretations, whenever these were ambiguous. This inference was made in the light of the total discussion, on the usual basis of assuming that the respondent's remarks, if complete, would form a coherent, consistent, logical whole and then supplying inferentially the minimum elements necessary to this basic assumption. Where flat contradictions were present, these were, of course, not rationalized out of existence, but, whenever it was not entirely clear what the respondent meant, the more consistent interpretation was chosen.

Two-thirds of the public (65 per cent) postulated some such innate or acquired "craving" or "addiction," which was generally conceived of in one of three ways. In the first two instances, the underlying predisposition was something in the nature of a compulsion--a compelling, irresistable drive toward alcohol, but the two versions differed in the manner in which they formulated the compelling quality of this impulse. In the most frequent case, used by 29 per cent of the public (or 44 per cent of those who made any reference to predispositional elements), the addictive quality of "Williams'" drive toward drinking was regarded as idiosyncratically but not intrinsically compelling. That is, the uncontrolled way in which "Williams" was pulled toward and succumbed to alcohol was viewed as a compulsion or addiction that could not be resisted by him, but only because of still more basic flaws in his character or weaknesses in his emotional structure. In contrast to this view in which "Williams'" domination by alcohol was essentially conceived of as moral weakness, 21 per cent of the public--31 per cent of those who mentioned predispositions--regarded alcohol itself, as intrinsically addictive and the craving for alcohol as a discrete, inherently unmasterable element in personality that was separate from and unrelated to general personality trends. The third approach to predisposition, used by a quarter of those who spoke of it at all (16 per cent of the entire population) made no positive reference to the notion of compulsiveness in alcoholism. In a third of these cases there was a clear assertion that the predisposition was not compelling, that "Williams'" drinking represented a deliberate, intentional, conscious indulgence of an appetite, while the majority referred only to a positive, subjective set toward alcohol--a "taste," "liking," "habit," or the like--in such a way that it was impossible to decide whether

or not compulsion was implied.[15]

[15] It should be pointed out that no assumptions were made about the meaning of words like "habit," "craving," or "alcoholism." The first two were interpreted as referring to a predisposition, but no inferences were drawn about the nature of the predisposition, except from the manner in which the person using such terms himself defined what he meant by them. "Alcoholism" was left as a completely problematical term, whose reference and meaning were to be entirely determined by whatever else was said about it, and is, therefore, not included in the discussion of predisposition above, except when further comments made clear that it was being used in a sense which included an element of innate or acquired predisposition.

These three ways of formulating the nature of the underlying addiction or predisposition were, of course, highly related to the descriptive psychological elements shown in Table 19. Thus, of those classified as regarding alcoholism as a "character compulsion" (i.e., as compelling because of a character defect), 90 per cent described "Williams" as "weak, self-indulgent, lacking will-power"; while 51 per cent of those classified as regarding alcoholism as an intrinsic compulsion described him as "driven by uncontrollable impulse."[16] Both the actual descriptions made and the

[16] The relationship between coder inferences about mechanism and actual psychological descriptions is shown below:

Description	Intrinsic compulsion	Character compulsion	Predisposition, but not clearly compulsion
Driven	51%	10%	1%
Weak	6	90	9
Deliberate . . .	5	12	35
Other description only	13	5	25
Vague description only	31	1	35
Total . .	106%	118%	105%

inferences drawn from them are typified by the following remarks:

Intrinsic compulsion: He got in a habit, little by little. Then he went too far. (C) It gets you in the end, until you lay in the streets and drink; it's just like a dopé fiend.

He just has the desire for liquor and he can't leave it alone; the more he drinks, the more he wants.

He craves liquor--even if he tries to stop, he can't.

He's formed a habit. (C) Drinking's a habit that grows on anybody. (C) He probably started out just taking one drink, and now he likes it so much he can't stop.

He just got started, and there ain't no stopping.

Character compulsion: It's the "big thirst"; they crave liquor. (C) Well, he can control it, but he ain't got the will-power to control himself. (C) If he fights it, he can control himself, but, when his thirst comes, he can't control his will-power.

He just has a weakness and can't control himself. (C) Alcoholism. (C) He's let a bad habit get control of him. (C) Because he has no self-control.

He's too weak to control his wanting a drink. He's formed a habit, and he's too weak to break it.

He's one of those alcoholisms. (C) He just has to get his belly full of liquor. (C) Because he ain't got no guts.

Love of liquor. (C) He's acquired a taste for it, and he just can't stay away from it. He has absolutely no will-power to stay away from liquor and that brings it on.

Subjective set: He's just a "cornhead." (C) He loves drink.

He just wants to do that. I think it's just a habit; he's a drunkard, that's all.

A bad habit, he has learned to like the taste of whiskey.

He's an alcoholic, has an urge to drink.

The origin of tastes or cravings of this kind was seldom dealt with more fully than most of these quotations imply. The typical approach was to assume that the predisposition was acquired by habituation: "He started to drink and got into the habit"; or "Once he began drinking, he developed

a taste for it." About a fifth of those who mentioned predispositional elements did, however, make more explicit what the essential process was. Within this group, about half were thinking of an acquired need based on the physical effects of alcohol--essentially, a physical addiction; a third felt that the taste or craving was innate--inherited, and a sixth traced the craving to organic disorders or anomolies like nutritional deficiencies or "something missing in his body" which resulted in his longing for alcohol to make up the lack. A few illustrations of these expanded accounts follow:

> Sometimes a person's body craves it. (C) After he has begun to drink, his body needs the alcohol. (C) It becomes habit-forming to satisfy the craving in his body.

> That man can't help it; it's a dope; it's in his system. He probably started out slowly, and then the system gets full of it, and his body craves it.

> Whiskey is like dope; they get so they have to have it.

> He has a physical craving for alcohol. (C) I think they are born with a weakness for alcohol. (C) I don't think they acquire it or lead up to it. (C) I don't think anything has to happen to make a man a drunkard. (C) I think they are born with a taste for it.

> He might have inherited the weakness for drink. (C) All the ones I ever knew, they inherited it; they tell me, when the parents drink, they inherit it.

> It's the fact that something is lacking in the physical make-up--maybe vitamins or something, and alcohol takes care of that lack.

For about two-fifths of the public, "Williams'" present reasons for drinking stopped here. In their view, "Williams" was now dominated by an antonomous, self-sustaining drive toward drinking which maintained itself even without any special precipitating events. Since this is a formulation which close approaches the idea of addiction, it should be expected that it occurred most frequently when the predispositional elements were conceived of as compelling: 73 percent of those who defined the impulse as either intrinsically compelling or irresistible because of character

weakness viewed drinking as self-perpetuating even in the absence of specific precipitants, as compared with 51 per cent of those who did not explicitly attribute this unmasterable quality to the underlying impulse to drink that they postulated. Once the impulse was defined as uncontrollable, it made little difference whether its unmanageability was attributed to its own intrinsic quality or to the character of the individual beset by it: of people with the former view, 77 per cent defined his drinking as a self-maintaining cycle; of people with the latter view, 71 per cent did.

At a somewhat different psychological level, 30 per cent of the public regarded "Williams'" drinking as an expression of his emotional or character difficulties. This point of view shared with the former the quality of a self-perpetuating system in that the essential reasons for drinking were inherent in him, and it was, in fact, about a third of the time, used in combination with a predispositional element. It differed from the autonomous predispositional approach, however, in offering a psychological interpretation of the significance of his drinking that was less concentrated on concrete, psychological appetities, tastes, and dispositions directly and entirely related to drinking. In this approach, "Williams'" drinking flowed from something in his character, but it was a "something" more generally conceived, of which the drinking was only one manifestation, rather than a character element specifically postulated to account only for drinking. Among this group who traced "Williams'" motives for drinking to his personality, many were not so much interpreting the psychological significance of his behavior, as they were deriving a moral judgment from it. Thus, 30 per cent simply concluded that he was weak and self-indulgent (apart from those who employed this character trend in predisposition); 18 per cent labelled him a lazy, irresponsible,

"ne'er-do-well" character; and 12 per cent said he was an immature, dependent personality.[17] In these versions, "Williams" drank because he was

[17]The frequency with which these psychological trends were used by the population as a whole is presented in Table 19.

self-indulgent, irresponsible or immature, and his drinking simultaneously reflected and demonstrated the existence of these character trends. Just about as frequently, however, psychological interpretations of the causes of "Williams'" present drinking viewed him as turning to alcohol in an attempt to secure relief from emotional conflicts. His drinking, thus, represented an effort, however erroneous, to overcome, flee or forget emotional difficulties rather than a direct expression of the emotional trends involved. Within the group who traced "Williams'" drinking to his psyche, he was most usually viewed as escaping into alcohol from an inability to face or cope with reality, 22 per cent; from feelings of inferiority or insecurity, 11 per cent; from anxiety, 10 per cent; and from frustration, 10 per cent. These psychological formulations were expressed as follows:

> Self-indulgence: He ain't got no self-control. (C) He does just what he wants and don't care who pays for it.
>
> That is selfishness mostly--it's an infantile attitude, they never grow up to learn to control themselves.
>
> He's diseased, a moral coward. (C) Just too weak to deny himself anything.
>
> He's a weak, selfish man--thinks only of his own pleasures.
>
> He could stop if he wanted to. It's just an "I don't care" attitude. (C) He just believes in having a good time.
>
> Irresponsibility: Lackadaisical, he just doesn't care. (C) He's more interested in drink than anything else.
>
> He doesn't want to accept any responsibilities, so he drinks to get out of things.

He's just not a responsible character, that's all. He just likes his drink better than he likes work.

Immaturity: They haven't got any responsibility, they just never grew up, they always want to be Mama's little boy. (C) They like being little boys because life is so nice and easy that way.

He has the mentality of a kid. (C) He has the brains of a child, just no sense of responsibility.

Flight from reality: Alcohol helps him to escape realities.

He's an escapist. (C) He doesn't want to face reality. When he drinks he's in a little world of his own, and then, when it wears off, he can't face things and goes back to drink again.

He's a chronic alcoholic. (C) I think this is a manifestation of the inability of a person to adjust to his surroundings. (C) He found life too difficult for him and gets release under the influence of alcohol.

Most cases of drunkenness is a means of dodging reality.

Inferiority: He is unsure of himself. (C) He probably wants to keep up with the Joneses or something, and in its impossibility he takes liquor to bolster his courage or his ego.

He's been disappointed in himself. (C) He might have had some trouble getting work and feels like he don't amount to anything.

Anxiety: He is drinking to escape his thoughts. (C) Well, as I said, his drinking is an escape from something that is worrying him.

Maybe he's bothered about the past, and he thinks he can forget it under the influence of whiskey. (C) He drinks because he's trying to forget something bad and trying to forget in this way.

Frustration: Anyone drinking a lot to excess, something causes that, but I don't know what. (C) Usually they're unhappy and dissatisfied with their lot and want to forget it.

It's something he's trying to forget. (C) The success that he'd like to attain but hasn't might cause it.

In the final popular version of why "Williams" drank, it was not so much his self as his realistic, external difficulties from which he fled into drink. Some 26 per cent of the public took this position and

were about equally divided between those who appeared to regard the precipitating events as good and sufficient reason to drink (14 per cent) and those who deplored turning to drink under the pressure of circumstances (12 per cent). In the former case, "Williams" was regarded as driven to drink by events; in the latter, he was equally viewed as driven by circumstances, but not necessarily to drink.[18] In either case, the problems pro-

[18] The figures cited in text may be somewhat confusing, because a few persons advanced alternative theories about why "Williams" drank and were, consequently, classified under more than one major approach. The following summary of interpretations of "Williams'" current drinking should help to clarify the data:

Present Reason for Drinking	Proportion of All Respondents Using Each Interpretation: Predisposition to Drink Precipitated by Given Reason	Drinking (without Predisposition) Precipitated by Given Reason	Total
Antonomous process	44	--	44
Emotional needs, character .	11	20	30
Realistic problems			
Defective solution	6	6	12
Reasonable response . . .	8	7	14
Total per cent . . .	65	31	95

Thus, about one per cent used alternate interpretations which involved both predisposition and no predisposition, two per cent mentioned an autonomous process in combination with one of the other possibilities, and two per cent mentioned emotional needs as an alternative to circumstantial factors.

voking "Williams'" drinking were formulated in about the same way, with marital and family difficulties being the chief source of stress and economic and job problems the only others frequently mentioned:

Nature of Problem	"Williams'" Drinking Viewed as: Defective Solution to Realistic Problems	Reasonable Response to Realistic Problems
Difficulties, problems in marital or family relations	41%	50%
Economic, financial difficulties	16	15
Job or career difficulties .	11	11
All other external stresses .	28	24
Vague external difficulties, frustrations	10	11
	106%	111%

For about a fifth of those who used this situational approach, "Williams'" problems were further complicated by association with people who drank themselves and encouraged him to drink.

These two environmental approaches to alcoholism were much the same in regarding the existence of acute or chronic realistic difficulties as a necessary condition of "Williams'" excessive drinking, but they differed in the extent to which they assigned exclusive responsibility for his drinking to his situation. Where his drinking was viewed as a defective solution to realistic problems, there was, expressed or implied, an element of character defect which led "Williams" to select drinking as an answer to his difficulties. This character defect was formulated in much the same ways as it was by those who traced his drinking entirely to his character or emotional needs: "Williams" was weak enough to let his problems drive him to drink, was too easily influenced by his friends, or lacked the perspective to see that drinking would not solve his problems, except temporarily. This explanation thus blended the view that his drinking reflected emotional problems wkth the notion that it was precipitated by objective provocations. This environmental approach to alcoholism is typified by the

following comments:

Defective solution: He could be brooding about something. (C) He may have sickness in the family, an excess pile of bills mounting up, and he's not helping them none.

It could be too much trouble or debts and everyone after him to pay up, and it drives him to drink to forget about the troubles. (C) I think they are weak and have no backbone to face life and take the easy way out of their troubles.

It could be many things. (C) A bad family life--if he didn't have a good wife or she doesn't keep his home right; if he would know that he has a sickness that can't be cured. (C) Some people get the idea they can forget that way. It doesn't really help, but they think it does.

Reasonable response: If he's drinking, he must be worried about something. (C) It could be he has money troubles; he would like to give more to his wife--more money--and can't.

His home life is at fault. It's between his wife and him--a wife can make or break a man. (C) Nine out of ten women run around with other men; they don't take care of their children and home. (C) A man who has a good home doesn't drink.

His surroundings are bad and impossible to live with. (C) His family drive him to drink in despair and disgust. (C) Maybe they demand too much or else demand what he cannot give them.

In these explanations of "Williams'" drinking, his general character was touched on by 67 per cent of the public, either in accounting for the compelling quality of his impulse toward alcohol or in explaining what motivated his drinking or led him to select drinking as a solution to his difficulties. "Williams'" psyche thus assumed central importance in the interpretations of a majority of the public, but it was, itself, generally postulated rather than accounted for. Only a fifth of those who introduced such psychological considerations in order to account for "Williams'" drinking commented on their origin. For this group who attempted to account for "Williams'" character, it was, about half the time, traced to the psychodynamics of his childhood; a quarter of the time, to other circumstances of his life; and a quarter of the time it was regarded as innate. Since

his personality was primarily conceived of in terms of weaknesses and defects, the general point-of-view on his childhood was that it had been one of overindulgence and inadequate discipline rather than an overly-depriving, repressive experience. Within the group who spoke of his childhood relationships at all, half spoke of his parents having been overly-protective or overindulgent, and a quarter felt that his parents had failed to teach him moral standards or strength of character, while only one person in fifteen mentioned lack of love and emotional security and a similar proportion spoke of excessive discipline. In contrast, when other circumstances in his life were adduced to account for his character, they were generally those which would account for his having become a bitter, disappointed man. Here are a few comments on the origin of "Williams'" character:

> It's their parents' fault. They never make them grow up to be self-reliant and learn to handle a dollar; don't train them right so they grow up like him.
>
> I think every child is born with willpower, but it is dormant until it is exercised, and he just never exercised his will enough to discipline himself. (C) In his guidance by his parents, he wasn't helped to form the right habits of discipline.
>
> He never acquired the habit of self-control. (C) His parents might have given him everything he ever wanted.
>
> Too much mother love. (C) When he gets older, he hasn't that protection from mother, and he finds it in liquor.
>
> He just doesn't care what people think of him. (C) Someone he thought a lot of could have done something to him that broke his spirit.
>
> He's a man who feels sorry for himself, so he drinks for the consolation. (C) He could have been down on his luck most of his life--lost his job, lost his best girl, and it all piled up till he feels sorry for himself all the time and drinks all the time, too.
>
> He has no will power, a weak man. (C) He was born that way.
>
> He can't leave alcohol alone because he lacks courage to face things as they are. (C) It would be heredity more than anything else.

These accounts of the factors maintaining or provoking "Williams'" current drinking constituted all that a majority of the American public said in explanation of alcoholism: 53 per cent did no more than outline the major mechanism as autonomous, emotionally-motivated or related to circumstances, while 20 per cent added to these interpretations some details about the source of his predisposition toward drinking or of his character defects and stopped at this point.[19] Anoter 22 per cent, however,

[19]It is, unfortunately, impossible to estimate to what extent the termination of popular discussions of alcoholism at these points was attributable to interviewer failures to pursue their questioning further and to what extent it represented all that these segments of the public had to say.

also developed their discussion in the direction of how "Williams" had happened to begin drinking originally.

Most of the people who explained how "Williams" had happened to begin drinking were trying to account for the process by which an autonomous predisposition had been established. Of the people who touched on the initiation of his drinking, 70 per cent attributed his present drinking to this kind of a self-sustaining drive, and 18 per cent included an element of predisposition in combination with his character or circumstances to account for his present drinking. In other words, it was primarily the people who saw a self-sustaining mechanism in drinking and secondarily those who felt some sort of predisposition was at least an element in it who tried to explain why "Williams" began to drink in the first place, while those who attributed drinking solely to his character and/or his circumstances were least likely to concern themselves with this question. (The proportions who explained the inception of "Williams'" pattern of excessive drinking were 36, 16 and 8 per cent, respectively.)

There were, essentially, two main theories to account for how

"Williams'" alcoholism had begun, each used about equally often. In the first version, he had begun to drink because of some realistic problem or problems and gradually become habituated to it until finally his drinking assumed autonomous proportions. The kinds of problems were in no way different from those cited by people who felt his drinking now was precipitated by external pressures; they were simply moved to an earlier period. The dominant point of view appeared to be that it was reasonable for a man to take a drink under those circumstances, but that there was always a danger inherent in the procedure. For instance:

> He could have been in service, and his wife ran around, and he heard about it and started to drink to forget. You can't blame him on that.
>
> I guess in the first place he must have been awful worried about something. (C) Oh, maybe his health, or money or his wife. He started to drink because it made him forget his troubles, and now he can't seem to stop.
>
> It could be it started as a minor habit to get a lift and take his mind off of his troubles. Then it became a habit like a drug habit.
>
> He has formed a habit of drinking until he must have a drink. (C) He may have had a physical illness or lost someone in his family--the alcohol deadens the pain.

In the other major version of the origin of "Williams'" alcoholism, the choice of drinking as a symptom was the result of a conditioning process.[20]

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[20]For "Bill Williams," only the categories shown in Table 22 under "direct, equivalent conditioning" were classified as such.

"Williams" had been taught to drink by his associates or learned it from their example. About three-quarters of the time, the people involved were his friends and companions; the rest of the time, "Williams" had learned to drink because of the example of his parents and, particularly, his father. Here are some typical accounts of "Williams'" exposure to alcohol:

> Someone took him into drink, either his companions or his parents. Maybe there was always liquor around the house, and he acquired a taste for it.
>
> Probably he was with some friends, before he got married, that were always drinking, and he got into the habit.
>
> He's been let drink too young. (C) He got it from his parents; his father, maybe, was a drunkard, too. (C) His father may have given it to him when he was a little boy, and he got to liking it. This is the way most of them start it.
>
> I think a person can get in the wrong company. He probably ran around with people who drank and took it up and couldn't quit.

The major dimensions of public discussion of "Bill Williams" have now been presented. He was seen as continuing to drink either because of a taste or craving for alcohol, or because of psychological trends like weakness, inability to face reality, and irresponsibility; or because of difficult circumstances. His predisposition toward alcohol was primarily acquired, though sometimes innate, and it was acquired, essentially, through continuing to drink. He had begun to drink by participating in social circumstances where other people were drinking or by trying it once as a relief from particularly acute circumstances, after which he had become habituated to alcohol.[21]

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[21] Because of the different levels of explanation employed, the materials presented in Tables 22-24 as "causes" of "Williams'" behavior are not as directly interpretable as they are in other instances. Instead, it is necessary to remember that organic causes were mentioned almost entirely in the context of accounting for predisposition; innate personality, in accounting for either predisposition or character; external circumstances, primarily as factors initiating or precipitating drinking and secondarily as influences shaping personality; conditioning, in accounting for either the initiating factors in drinking or situations tending to maintain it; and psychodynamic relationships, in explaining personality formation. Once these translations are made, it is possible to tell, from Table 23, that the people who called "Williams" mentally-ill were talking about approximately the same elements in drinking as were the people who did not; or, from Table 24, that people who called drinking a physical illness were more likely than any other group to account for the origin of predispositions. These relationships will be presented more directly, however, so that Tables 22-24 may be largely ignored in this case.

Since the words, "alcoholism" and "habit," entered so often into popular discussion of "Bill Williams'" drinking, their implications deserve somewhat closer attention than they have received up to now. It is significant, to begin with, that, although each of these key words was used equally often, the two were seldom used together. Twenty-three per cent of the public called "Williams'" drinking a habit or a bad habit, and 23 per cent called him an alcoholic or his drinking, alcoholism, but only five per cent used both terms in discussing him. For the most part, then, these two words were used independently, by different groups of people, and actually were the focal points of two quite different general orientations toward the problems of excessive drinking.

This difference in orientation appeared to be, primarily, the difference between a moral and a medical approach to excessive drinking. A discussion of habits led almost inevitably to a consideration of character, while alcoholism pointed toward illness: "Williams'" habits were "bad," but an alcoholic was "sick." This way of putting it somewhat overstates the case, but 56 per cent of those who viewed "Williams" as an alcoholic called him ill, as compared with 27 per cent of those who approached "Williams" in terms of his habits. In fact, the proportions who classified him as mentally-ill, on the one hand, and as a morally-defective character, on the other, were exactly reversed in the two schools of thought. In the group favoring alcoholism, 42 per cent said "Williams" was mentally-ill and 20 per cent called him a defective character, while the group using habit contained 20 per cent who said he was mentally-ill and 42 per cent who condemned his character:[22]

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[22] As might be expected, the relatively small group who used both terms were roughly half way between these two extremes--30 per cent classified "Williams" as an instance of mental illness and 30 per cent regarded him as an instance of faulty character. The majority of the public (59 per cent), who used neither term, also fell between the two polar positions, although they were closer to the point of view implied by habit than to that implied by alcoholism--27 per cent of them perceived mental illness; 38 per cent, character flaws.

"Williams" Categorized as Instance of	"Williams'" Drinking Defined as: Alcoholism	Habit
Mental Illness	42%	20%
Physical illness	6	2
Other illness	8	5
Temperament, conditioning, personality	24	31
Bad will, defective character . .	20	42
	100%	100%

If we turn to the more concrete accounts of the source and significance of excessive drinking which were advanced by these two groups, however, there is little in them to explain why the key words, alcoholism and habit, epitomized such differences in general approach. True, "habit" was always interpreted as referring to an underlying predisposition, while only two-thirds of the group discussing alcoholism introduced predispositional elements. And, in line with this difference, the "habit" of drinking was much more likely to be defined as an autonomous mechanism built up by conditioning than was alcoholism. Nevertheless, where predisposition was used in connection with the term, alcoholism, it was described in about the same fashion as it was when called a habit, and the view that "Williams'" current drinking was maintained by the sheer force of this predisposition was the most frequent explanation in both the habit and the alcoholism approaches, with the alternative explanations in terms of character, circumstances or both following in the same order within each group:

Present Reason for Drinking:	"Williams'" Drinking Described as: Alcoholism	Habit
Autonomous process	45%	72%
Character, emotional need	28	17
Circumstances		
Defection response . . .	12	6
Reasonable response . .	15	10
No explanation	2	--
	102%	105%

In any case, these differences in the way the significance of "Williams'" drinking was explained by those who called it habit and those who called it alcoholism do not account for the tendency to define habit as faulty character and alcoholism as illness. For instance, in the entire population, of those who described drinking as an autonomous process, 38 per cent called "Williams" ill and 34 percent called him a faulty character; while, among those who attributed drinking to character or emotional needs, 38 per cent called him ill and 43 per cent condemned his character. Without presenting all the data, it can be said that, if current reasons for drinking were the decisive factor, there would have been no differences between the alcoholic and habit groups in the extent to which drinking was perceived as illness, and the former group would have been somewhat more likely than the latter to perceive character defects.

The data available simply do not explain why alcoholism was popularly used to imply illness, while habit led to questions of goodness and badness. Yet, this distinction is clearly apparent not only in the figures which have been presented but in a variety of other data as well. Thus, to the extent that "Williams'" personality--apart from his predisposition toward alcohol--was described at all, those who identified alcoholism tended to use quasi-psychiatric analyses, while those who recognized the operation of a habit tended to express moral judgments: those who called "Williams" an alcoholic were most likely to describe him as an insecure man who was unable to face realities, while those who spoke of his habits were most likely to characterize him as an irresponsible person with an improper outlook on life. Quite consistently, the people who were discussing "Williams'" habits were over twice as likely as those who were talking about alcoholism to assert that "Williams" could reform himself if he chose to.

The whole problem of differences in popular approaches to alcoholism primarily depends on whatever difference is involved in calling behavior a

mental illness as against calling it a character defect. It has been suggested that use of illness categories implied referring excessive drinking to a "healthy-sick" dimension, while character referred to a "good-bad" dimension. Nevertheless, it should not be lightly assumed that mental illness invariably had this connotation of "sick" rather than "bad." If the explanations of excessive drinking advanced by people who called "Williams" mentally-ill are compared with those of people who assigned him to other categories, a number of interesting differences and similarities emerge, as shown below:

	"Williams'" Behavior Categorized as:				
ALL RESPONDENTS Present Reason for Drinking	Mental Illness	Other Illness	Physical Illness	Temperament Personality	Defective Character
Autonomous predisposition	42%	51%	67%	52%	43%
Character, emotional needs	35	21	14	22	39
Circumstances					
Defective solution . . .	12	10	6	8	16
Reasonable response . .	12	19	9	17	6
No explanation	5	7	9	5	1
	106%	108%	105%	104%	105%
Proportion using predisposition	64	72	83	73	66
Proportion describing predisposition as:					
Intrinsic compulsion . .	22	31	52	32	9
Character compulsion . .	32	25	23	10	43
RESPONDENTS WHO USED PREDISPOSITION					
Proportion defining it as autonomous	65	70	80	71	65
Proportion describing it as:					
Intrinsic compulsion . .	34	43	62	44	15
Character compulsion . .	50	35	28	14	65

As these data make clear, when alcoholism was classified as a physical disorder, it was described in terms which most closely approached a conception of an addiction. Four-fifths of the people who called "Williams" physically ill thought of his drinking as based on an innate or acquired predisposition; two-thirds viewed his drinking as sufficiently explained by the existence of this self-perpetuating drive; and over half defined his urge toward alcohol as intrinsically compelling. This view of "Williams" as a man dominated by an uncontrollable craving reached its peak in the group who called him physically ill. It dropped rather sharply in the groups who regarded him as either a personality type or as a man with an illness sui generis, and was at its lowest in the groups who called him mentally-ill, on the one hand, and a defective character, on the other.

There were a number of ways in which the group who called excessive drinking mental illness and the group who regarded it as faulty character resembled one another. They were, for example, the two groups who least often introduced predispositional elements into their interpretations. They were also the only two groups in which the predisposition was more often defined as compelling because of "Williams'" character than as compelling because of its own intrinsic quality. Similarly, when they did use predispositions in explaining alcoholism, they were least likely to regard them as autonomous. They were, in fact, the only groups in which less than a majority attributed "Williams'" drinking to an autonomous predisposition, and they were the two groups in which his drinking was most frequently traced to his emotional or character difficulties.

The interpretation in terms of character defect differed from the mental illness version in only two ways, aside from the basic difference in diagnosis. The group who called "Williams'" drinking a character defect

was even more likely than those who called it mental illness to attribute the compelling quality of his urge to drink to his weakness of character--57 per cent of them called him weak or lacking in will-power as compared with 39 per cent of those who called him mentally-ill and still lower proportions in the other groups. And, the leading character interpretation of the emotional significance of his drinking was in terms of his irresponsibility (mentioned by 17 per cent of those who called him a faulty character and five per cent of those who called him mentally ill), while the mental illness group often saw "Williams" as resorting to alcohol because of his inability to face reality--16 per cent of them as compared with six per cent of the group who classed him a faulty character mentioned this trend.

It is apparent then, that the two groups differed in the extent to which they regarded "Williams" as a person who was or ought to be fully responsible for his actions and, therefore, to be judged in terms of his behavior, with the group who called him a defective character most likely to hold him morally accountable.[23] What should not be lost sight of, however, is that, in comparison with other possible ways of classifying his behavior, the category of mental illness came closest to the moral flavor of the character approach and was almost as far from the neutral image of physical illness as character was. At least as far as alcoholism is concerned, there was not always much difference between calling a person a poor character and calling him mentally ill. In fact, "Williams" was called mentally ill <u>because</u> of his character defect almost as often as he was

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[23] It should be pointed out that, while saying a person is a "no-good, irresponsible bum" more clearly expressed disapproval than saying "he's escaping reality," there was nothing in the latter statement which precluded equal disapproval of the person on that account.

called not mentally-ill because of it.

As has just been suggested, the question of whether or not the kind of excessive drinking typified by "Bill Williams" was to be classed as mental illness revolved primarily around the logical status of "weakness" or lack of "will-power." Of those who said he was mentally-ill, 28 per cent explained that they classified him this way because his behavior exhibited weakness, self-indulgence or failure to exercise self-control, and 24 per cent based their decision on the uncontrolled quality of his behavior without so clearly stating or implying that he was or should be able to control himself. No other reasons were mentioned by as many as ten per cent of the group except for the essentially factual comment that prolonged use of alcohol could cause organic damage to the nervous system. Quite similarly, however, the most frequently used reason for saying he was not mentally-ill was the belief that his behavior typified weakness, self-indulgence or failure to exercise self-control which the individual could and should correct himself. This line of reasoning was adopted by 16 per cent of those who said he was not mentally-ill--a third of those who gave classifiable reasons for their position. (See Tables 27-28.) These contradictory approaches to human weakness are exemplified by the following comments, explaining why "Williams" was or was not considered to be mentally-ill:

> Mental illness: He has let it get the best of him. Instead of trying to solve his own problems, he was taken to drink.
>
> He says he won't do it, but he isn't strong enough to stick by it.
>
> It's a weakness, and don't you think any kind of weakness is a mental illness?
>
> He hasn't learned to control his will-power.
>
> I think the lack of will-power and self-control is a mental weakness, for he knows within himself that it isn't good for him and yet he goes on and drinks any way.

Because he has absolutely no will-power to keep away from liquor. (C) He must have a very weak mind.

Not mental illness: A man that drinks could control himself if he wanted to.

That's just lack of control of appetite.

It isn't, because he can control that, if he wants to--he should be able to. (C) It doesn't seem to me it's mental when he does it of his own free will and accord.

It's just a habit. He may be mentally weak, but not ill.

People say they are sick but I think it is just selfishness on his part. He doesn't want to help himself.

He ain't got no guts. (C) If he'd just make up his mind he was going to quit, he could do it. I don't think mentally-ill people could just make up their minds to something and do it.

Aside from this direct attention to the relation between self-control and mental illness, there were two other considerations which entered into the decision that "Williams" was not mentally-ill with some frequency. The first of these, cited by 13 per cent of those who said he was not mentally-ill or a quarter of those who gave classifiable reasons, was the belief that "Williams'" problems were physical rather than mental. This point of view ranged from a simple assertion that his behavior resulted from alcohol (which is a physical substance) or from intoxication (which is a physical state) to an assignment of tastes, appetites and even will-power to the realm of the physical. This point of view was, again, counter-balanced by the 12 per cent of those who said "Williams" was mentally-ill who pointed out that alcohol, though a physical agent, could produce an organic mental illness. For instance:

Mental illness: It depends on how far along it is; alcohol can affect the brain.

Because he is an alcoholic. (C) He drinks too much and this works on his head. (C) Drinking to excess affects the brain. It works on the blood stream and poisons you in time.

His excess drinking would cause a mental illness eventually. (C) The alcohol can affect the mind.

It's the drink that brings it on. They become alcoholics and mentally-ill. They have hallucinations and are ill physically and mentally from the drink.

He might drink enough to impair the brain. It can do that.

Not mental illness: It's the drug in his body. If he quit drinking, he'd be better.

It's not a mental illness because it's mental while he's drunk only. (C) He's not responsible for what he does while drunk, but it leaves him right away when the alcohol is out of his system.

He's ill, just a man who wants to drink like some people want to eat, so they overeat. (C) There's nothing mental about it; it's a physical craving.

Because I think it's just a habit or a physical craving like wanting water.

He is just weak physically. Any man could break a habit if he wanted to.

Resisting temptation is more physical than mental.

Finally, some nine per cent of the people who did not regard "Williams" as mentally-ill--a sixth of those who gave classifiable reasons--felt that the absence of intellectual deterioration was proof that "Williams" was not mentally-ill. This position usually entailed one or another of the preceding lines of thought as well. That is, it generally involved recognition that "Williams" sometimes "didn't know what he was doing," but only when he was intoxicated rather than all the time; and, in concentrating on cognitive impairment, people were, in essence, dealing with the question of "Williams'" responsibility for his acts, but using a legal rather than a moral approach. This criterion of mental illness was much the same as that used by the large group of people who said "Williams" was mentally-ill because he was out of control, but there was, of course, a sharp disagreement in

interpreting the facts of the case. Again, people speak for themselves:

> Mental illness: No one in possession of their senses would deliberately ruin their life like this.
>
> When they're drinking, they'll do anything; they have no control and don't know what they are doing.
>
> A reasonable man wouldn't act like that.
>
> Nobody in their right mind would keep on drinking like this.
>
> He's doing something that he knows isn't good for him, so his brain can't be working right.
>
> It's a mental illness to have to drink like that.
>
> Not mental illness: He knows better if he tells his wife about it. He's got sense enough to know he's doing wrong.
>
> He's got sense enough to buy a drink when he wants it, and sense enough to go back to work when he gets over it.
>
> He's keen in mind and as alert as anybody, when he's not drinking.
>
> There are times when he's perfectly normal and knows he's doing wrong.
>
> When he is sober, he thinks all right, or he wouldn't feel sorry and beg his wife to forgive him.
>
> He realizes what he is doing, and a mentally-ill person wouldn't.

Although considerations like these usually led to the conclusion that "Williams" was not mentally-ill, the minority who did perceive mental illness took a quite serious view of it. Close to three-quarters of them (73 per cent) said it was a serious mental illness, the highest proportion for any of the six examples. (Table 15.) Their reasons for regarding alcoholism as a serious mental illness stressed, primarily, its social consequences and, secondarily, its implications for the life of the alcoholic.[24] Thus,

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[24] These were in addition the usual comments about the need for treatment, the possibility of psychosis developing or the possible incurability of "Williams'" condition. These were, generally, added to one or another of the major viewpoints, with only 22 per cent mentioning reasons that did not include them.

well over half the group (59 per cent) mentioned social considerations, first, that he was disrupting his family and, second, that he might become dangerous to others or socially undesirable in other ways--crime, dependency and the like. (Table 29.) Illustratively:

> All the discomfort and things he is causing his family would make it serious.
>
> It's very serious to his family, affects their security. He's on his way to becoming a public charge and his family a welfare case.
>
> It's the suffering he is causing his family.
>
> It disrupts a wholesome family life and is detrimental to his children.
>
> The disregard for his family is serious.
>
> If a man could drink and just let it affect himself, all right; but any man who drinks hurts everybody he comes in contact with, whether they love him or not.
>
> He isn't living up to his duties to the community. Everyone should contribute his share, and it's impossible to do this under alcohol.
>
> He could get into mischief and meanness. He could commit crimes, murder, even.
>
> Alcoholics sometimes lose their minds and threaten to kill.

Beyond the problems "Williams" was creating for others, 42 per cent of those who saw his illness as serious were concerned about what he was doing to himself. (Concern with both the social and individual aspects was expressed by 26 per cent.) They spoke of him as engaged in destroying himself socially, morally or physically:

> He'll be a bum and be put in an asylum.
>
> He'll get worse and lay in the gutter. He's ruining himself.
>
> He's ruining his life and his family's. (C) He's losing everything worth living for--self-respect, health, happiness, everything.

It could reach a point where it wrecks his life. (C) He could lose his job and end up ragged and hungry on Skid Row.

He'll soon be ruined physically; his body will be weakened, and later his mind will be lost.

He'll get physically sick too; alcoholism is the fourth in order of causes of death.

On the other side of the case, the minority who did not regard his mental illness as serious were thinking almost exclusively of the curability of alcoholism. Most frequently mentioned as means of treatment were, first, self-help and second, psychological assistance from lay persons around him--family, friends, and so on.[25] Here are viewpoints on the treatment of alcoholism:

[25]References to Alcoholics Anonymous were included in this category.

There's nothing he can't cure by himself, if he wants to see the facts straight.

He could control himself and leave it alone if he wanted to.

A little effort on his part, and he could overcome it, and his wife could help him along too.

He just needs to join Alcoholics Anonymous. It can be stopped, if the man has any self control.

If someone would talk to these people it would help. They need someone to lean on.

He can be helped. (C) He needs competent medical or mental health advice to get out of it.

Because the habit he has can be cured.

He's never done anything but drink, and this can be cured with the proper aid.

As must be clear by now, "Williams'" alcoholism posed to the American public primarily a moral problem. Close to half (48 per cent) of those who did not regard him as mentally-ill--and they were two-thirds of the group

making any action recommendations in a non-mental illness context--took the position that this was a problem which "Williams" could and should resolve for himself. (Table 31.) Next, but less than a third as often, "Williams'" difficulties were seen as posing a physical problem, even though medical treatment was seldom mentioned. Quite consistently, self-help was also the leading treatment suggestion of people who called "Williams" mentally-ill, although only a minority of them spoke in terms of treatment. (Table 32.) The treatment of mental illness by self-help was mentioned even more frequently in connection with the anxiety neurotic and the obsessive-compulsive, but in no instance did it so far exceed mentions of psychiatric help as in the case of "Bill Williams." And, as the next example will make clear, these self-help suggestions were more often intended to convey the simplicity of the problem and less often to announce the kind of moral disapproval with which 'Bill Williams" was surrounded.

The Story of "George Brown"

"George Brown," it may be recalled, was described in terms of the symptoms of moderate anxiety neurosis, as a man who was functioning relatively successfully in his career, but with excessive emotional costs manifested in "touchiness," chronic worry, "moodiness," depression and insomnia. Given this description, less than a fifth of the public regarded him as mentally-ill, while just about half said there was nothing at all wrong with him. (Table 12.) The minority who did perceive "Brown" as mentally-ill were not inclined to take a serious view of his illness: one-third of them called it serious, a proportion which was lower than for any of the three preceding examples and which was second-lowest of all six examples. To the extent

that "Brown's" illness was identified, it was perceived as non-psychotic by about a ten to one ratio, and the majority of those who saw it as non-psychotic recognized it as their familiar syndrome of "nerves" or "nervousness" (Table 15).

As with all the preceding examples, the leading alternative to regarding "George Brown" as mentally-ill was to conceive of him as a personality type. Over 60 per cent of the public--some three-fourths of those who did not regard him as mentally-ill--viewed him, essentially, in this way, and--like the "quiet" girl, but unlike the alcoholic and paranoid--depiction of his personality was seldom critical or disapproving. Where "Brown" did not emerge as a personality type, he was about equally often conceived of as having a nervous or physical illness, on the one hand, or as responding to the circumstances in which he currently found himself, on the other. As always, use of either of these alternatives to personality concepts meant that his emotional responses were being viewed as the inevitable, expected human reactions to the physical or environmental stresses perceived to be operating, rather than as individualized personality patterns. (Table 16.) And, as has thus far always been the case, there was, aside from a greater emphasis on illness by those who saw his behavior as problematical, relatively little difference in the way the essentials of "Brown's" story were categorized by those who saw "nothing wrong" with him and those who saw some problem. (Table 17.)

In characterizing the man they were about to explain, people generally began with a repetition of his key traits. So, the three leading psychological trends mentioned in connection with "George Brown" were, as shown in Table 19, that he was worried, fearful or anxious, cited by 43 per cent; tense, jumpy, restless, or unable to relax, mentioned by 20

per cent, and irritable, excitable, sensitive or easily upset, mentioned by 16 per cent. Similar in intent to establish a preliminary descriptive statement of what was to be explained, though somewhat less frequently used, were characterizations of "Brown" in terms of personality type. Thus, 15 per cent called him "nervous" or a "nervous" type and 11 per cent used other such type words, chief among which were terms like "worrier" and "worrywart." Even less frequently, other elements from the description which had been offered were reiterated: nine per cent referred to his brooding and eight per cent to his being aggressive and difficult in interpersonal dealings. Here are some typical comments:

> He just worries too much. People who are high strung like that just naturally worry.
>
> I wouldn't think there's a thing wrong but his nerves. A person in debt deep or depending on a crop deep to meet expenses, there's a doubt there. A person can really get sick over worry.
>
> He's what my granddaddy would call a worrier; he keeps on thinking and fretting over every little thing, and then, from lack of rest, he snaps you back when you speak to him and he flares up in a temper.
>
> That man just has a quick, flashy temper. He simply can't sleep, for he can't get his mind quiet from worry.
>
> He's just worried. (C) He don't like for nobody to cross his path. He gets worried and mad about it.
>
> He's always looking for trouble and brooding or worrying over things he can't rectify.
>
> I'd think he was a nervous type. (C) He's temperamental, flies off the handle; just a high-strung person with something on his mind.
>
> He's a chronic worrier. (C) He's afraid, and that could be the reason for his grouchiness and being ill-tempered.

As some of the preceding illustrations suggest, these descriptive elements, which together make up a typical anxiety syndrome, were sometimes

called upon to explain one another. In a somewhat related fashion, a number of psychological interpretations were introduced to explain the significance of "George Brown's" behavior, although interpretation was, generally, less frequent than pure description. Chief among these psychological interpretations was that of insecurity or lack of self-confidence. About 12 per cent discussed "Brown" in these terms, accounting for his symptoms as expressions of underlying insecurity, which, about a sixth of the time, was identified as an inferiority complex. For instance:

> An inferiority complex, brought on by an insecure feeling.
>
> He probably thinks he's not good enough or can't quite live up to his job. He hasn't enough confidence in himself.
>
> Maybe he is not sure of what he is doing, not sure of his own ability. If he was sure of himself and knew he was right, he wouldn't worry.
>
> Some feeling of insecurity. (C) He may worry about the possibility of losing his job and is always on the defensive about it. (C) He probably comes in contact with those he feels inferior to and is attempting to build up a sense of being more important than he actually is.

Or, in descending frequency, his behavior might be viewed as an expression of disappointment, dissatisfaction or frustration; as demonstrating his egocentricity, selfishness or overly-demanding attitude toward life; as indicative of lack of perspective on himself or on life; as weakness or self-indulgence; or as a manifestation of guilt or self-condemnation. Here is the way such ideas were put:

> Frustration: Possibly he isn't quite contented either in his business life or his personal life.
>
> It's just some frustration. (C) He's misplaced in his environment, and he is not interested or else not in the right job.
>
> (S) He's growing old ungracefully. (P) He's probably worried about the future, feels he's growing old, dissatisfied about the past, anxiety about the future.

Egocentricity: He has not been able to adjust himself properly. (C) He was probably spoiled as a child and, for this reason, he can't look at life realistically. He was spoiled, and had everything as a child. So, whenever he doesn't get everything just as he wants it, he can't understand it and doesn't know how to adjust himself to unpleasant situations.

I would say he is selfish and mean and thinks no one can be right but him.

I'd say he's a self-centered egotist, one who believes he's the only "Big I," and everything must go his way or else.

Lack of perspective: He has a bad outlook on life, can't ever see good in anything. (C) He just naturally likes to fret and worry, that's all.

He just takes things too seriously. (C) He lives too much in the future. He has a blue print and if he isn't able to follow it, he is worried about it. He should just take life as it comes.

He is a little off-balance to let his thinking be so one-sided and worry so much. He just seems to look for the dark side of life.

Self-indulgence: He's just the worrying type who makes a habit of it and doesn't try to quit.

(S) He's just bad tempered. He isn't agreeable to people. (P) Maybe he doesn't get along good with his wife, and he's just letting it make him mean. He's got so he feels sorry for himself and lays awake thinking how bad off he is. (C) He hasn't got any will-power or he'd straighten out what was bothering him.

He only lets his imagination run away with himself. If they don't have trouble, they imagine they do. (C) I don't think anything has happened. He just don't try to control his thinking or thoughts.

Guilt: Maybe he feels bad after he loses his temper and wishes he hadn't.

He is guilty of something or he thinks he did something very wrong a lot of years ago, and now he cannot shake it from his sub-conscious mind for he has harbored it in his inner thoughts so long now.

He has something on his mind to make him act like that. He may have committed a crime previously, and now his conscience won't let him rest.

As presented in Tables 18 and 21, some 91 per cent of the public described or interpreted "George Brown," and over ninety per cent of them did so in terms of the psychological trends which have just been outlined. It is also apparent in Table 21 that there was a high degree of agreement about "Brown's" psychological makeup between those who saw him as mentally-ill and those who discerned nothing wrong with him. While the psychological trends of anxiety, insecurity and brooding were mentioned by the group who perceived him as mentally-ill with statistically-significantly higher frequencies than they were by those who regarded him as non-problematical, these differences were relatively small. For the eight other leading trends shown in Table 21, there were no significant differences between groups, and all of the eleven most frequently-mentioned psychological categories had about the same rank order in each group, regardless of the general way in which "Brown's" behavior was classified. Once again, then, the final classification assigned to "Brown" and his problems had relatively little to do with the psychological terms in which he was perceived.

Like "Bill Williams," discussion of "George Brown" was rather frequently dropped at this point: 40 per cent did not go on to talk of the causes of his behavior in non-psychological terms. Within this group were three per cent who could say nothing at all about "Brown's" behavior, 21 per cent who made no reference to the causes of the psychological trends they described, and nine per cent who assigned causal significance to his personality or willed acts. Where causal discussion was carried beyond this point, it was almost entirely limited to factors operating in his present life or his immediate past, just as it had been with the other two male adults, "Frank Jones" and "Bill Williams." As shown in Table 25, for every person who referred only to factors in his childhood in accounting for

"George Brown," there were four who spoke only of his adult life. And, consistently with the other men, these immediate kinds of factors dominated explanations, whether of mental illness, nervous illness, or personality. (Table 26.)

Aside from the 15 per cent (close to a quarter of those who discussed classifiable causes for "George Brown") who explained him either as a constitutional type or as a man paying the price of his own wrongdoings, "Brown" was primarily viewed as a product of environmental stress and strain (Table 22.) Well over half of those who talked about causes at all turned to the theme of "money troubles," "job troubles," and "family troubles" as the sources of his behavior. For instance:

> Maybe he has troubles at home. (C) Worriment--marital troubles and a lot of bills.
>
> Maybe he doesn't like the men he works with. (C) Maybe they pick on him, maybe they're jealous of him. (P) Maybe his job is too big for him, and he can't do as well as he'd like, and he may be afraid he'll lose it.
>
> Possibly he isn't quite contented either in his business life or personal life. (C) Possibly he has financial worries.
>
> It sounds like he's overworked or his job is too big for him. (C) I would think his condition was all caused from trying to hold down a job that is too big for him. It would cause all these symptoms and make him lose his temper quickly.
>
> He probably has a monotonous job that's aggravating, and he probably doesn't have enough money. (P) His financial troubles are probably the main thing, or the situation in the country--unemployment, war, and so on--could worry him.
>
> Maybe his wife is always telling him he could do better. Perhaps, ordinarily, he'd be satisfied, but she makes him worry that he isn't doing better.
>
> Coffee nerves, or maybe he drinks, too. (P) A wife that nags, or neighbors might borrow his tools and not return them. Anything, any aggravation can make a man like that.

> At some time or another he has made a big mistake in his job and got fired or something. It worries him because he is afraid he will do something wrong again.
>
> He could have had somebody do something bad--like beat him out of something, made him lose his job, and he is still looking for it to happen all over again.
>
> He probably had a very poor home as a child, probably not enough clothes or food. He worries that his children will go through the same trials as he did.
>
> Could be he had so little when he was a child that he can't be satisfied with what he has now. (C) He can't rest at night because of his finances, afraid he'll lose what little he has and be like he was when he was small.

It is apparent, in these illustrative comments, that environmental pressures like these were conceived of in three rather distinct ways: "Brown" was simply reacting momentarily in a typical human fashion to an immediately frustrating or uncomfortable situation; he had come to be a psychological type (who might or might not be mentally-ill) chronically and characteristically given to such reactions because of the endemic tensions of modern life, the persistent or acute forms of stress which he had experienced, and the like; or he had "broken" under the strains and become mentally or nervously ill. Because the significance of environmental factors can be conceived of in these varying ways, they were employed to explain "Brown," when he was perceived as non-problematic, about as frequently as when he was perceived as mentally-ill, and led equally well to the conclusion that he was a personality type or that he had a nervous illness. (See Tables 23-24.)

Physical stresses and strains were the next most frequent causes introduced into the discussion of "George Brown." These were touched on by some 18 per cent of the public and were, in essence, not particularly different from the point of view implied by the environmental approach. In fact, physical stresses were frequently employed in combination with

environmental stresses, and differed from them primarily in introducing the idea of an organic process by means of which external pressures affected the individual. For these people, "George Brown" was overworked, tired, rundown or ill, a physical condition which either resulted from realistic pressures and problems or diminished his ability to cope with them equably. They said:

> (S) He's got ulcers, but I wouldn't say there was anything mental about it. (C) It's a physical weakness. (C) Possibly his work is too exacting, and he hasn't the physical ability to stand up under the strain.
>
> He might be working too hard and don't rest enough, or he may not get enough sleep. That always makes people nervous and on edge.
>
> Maybe he overworked himself. (C) I would say that possibly he was physically exhausted to the point where he was very nervous.
>
> (S) I'd think he was a nervous type. (C) I guess it's because he feels bad. Lots of times people are just sick and ill-tempered with everyone, but I just couldn't say. (C) A lot of people can get this way over debts and financial troubles.
>
> Probably working too hard. (C) He's tired, that's about all that's wrong with him. (C) When you're tired and worn out, you lose your temper and your patience.
>
> It could be the condition of his health--if they're not in good health and ailing.
>
> He could have some kind of disease. (C) Most any kind of disease--high blood pressure can keep you from sleeping and high-tempered all the time.

As was generally the case, the use of organic factors in explaining "George Brown" tended to lead to the conclusion that he was ill, in some fashion, except when the physical state was regarded as too minor or too transient to justify the term, illness. These were, of course, the leading causes advanced by people who regarded "Brown" as physically-ill. But, they were also cited disproportionately in the context of nervous illness,

the major contrast between mental illness and nervous illness being the relative prominence given to these diffuse organic processes (as distinct from brain and nervous system damage) in the latter.

Only one other line of causal speculation appeared with any prominence in people's discussion of "Brown." This was the area of psychodynamic relationships, referred to by 11 per cent--exactly the same proportion as had spoken in these terms about the other male adult examples.[25]

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[25]The low frequency with which direct, equivalent conditioning was employed in explanation of "George Brown" is entirely attributable to the fact that no special categories of interpersonal relationships were defined as this kind of conditioning for him. The essential ingredient of this limited conditioning theory is, of course, that symptoms, in the concrete form in which they were presented, have a one-to-one correspondence with their causes, without the intervention of any symbolism or interpretation of the psychological significance of the behavioral manifestations. Since "Brown's" symptoms were primarily presented as a diffused, generalized anxiety, it was difficult, if not impossible, to single out direct conditioning events of specific symptoms. For instance, even a recognition that "Brown's" irritability, tension, etc. was an expression of anxiety or insecurity meant that a conditioning theory of causation, if used, would be accounting for the anxiety or insecurity and would not have the direct, equivalent quality that we have singled out. In the case of "George Brown," environmental determinism, especially where difficulties in his present job were traced to past job difficulties, approximated the basic characteristic of direct, equivalent conditioning, but it was not so classified because of the difficulty of discriminating its use as special conditioning theory from its use as more diffuse environmental stress.

As was previously the case, the psychodynamics of "George Brown's" character clustered about the two poles of overindulgence and lack of moral development, on the one hand, and deprivation, rejection and repression, on the other. Like the alcoholic, but unlike the two psychotics, "Brown" was somewhat more often viewed as a failure in moral discipline and development than as a victim of harsh emotional demands. For this reason, psychodynamics were mentioned in a context of disapproval of "Brown" as a character type relatively more frequently than they were employed with either neutral personality

evaluation or explanation of mental illness. The points of view on "Brown's" parental relationships are exemplified by these comments:

Over-indulgence: When he was younger, he had a doting mother who made him feel superior to other children his age.

He is characteristic of a spoiled person who was not taught to think of other people.

He's probably used to having his own way all the time and doesn't like it if he doesn't get ut, (C) He probably had his own way at home, when a child.

He was probably an only child, and his parents spoiled him and let him have his way, didn't teach him how to "live and let live" and get along with people.

Probably that has been in his training when he was smaller, when they didn't try to control his temper. When he would tear things up, they didn't show him where he was wrong.

Over-thwarting: His could have started as a child. His family relations were unhappy at home, where maybe a stepparent disapproved of him. He tried hard, but he couldn't please his parents, so he began to worry about it, and, gradually, it shifted to his job and other things, as he grew up. He still expects criticism, so he is irritable with people.

From childhood, I believe it would be the cause of a person acting this way. (C) Well, a broken home, or harsh parents, or maybe they just didn't show the proper amount of love and affection--this would cause him to have an insecure feeling.

Maybe his background has a lot to do with it. (C) Maybe when he was growing up, his parents didn't have confidence in him, and possibly they did things that he thought were an injustice to him. (C) Maybe they lied to him and promised him things and didn't keep their promises.

In a way that must be familiar by now, we must turn less to psychological perceptions of "Brown's" problems and the causes adduced for them than to underlying rationales, in order to account for the infrequency with which he was termed mentally-ill. That is to say, as was generally the case, there was more similarity than difference in the way "Brown" was perceived and accounted for, whether he was called mentally-ill, problematic or non-problematic, so that general conceptions of mental illness assumed greater relevance

for the determination of the nature of his problems than did variations in the way these problems were conceived of.

From Table 27, it is clear that "Brown," like the schizophrenic girl, was an instance where the primary consideration in arriving at a conclusion that he was mentally-ill was the deviancy with which he perceived and responded to the world and himself. For 42 per cent of those who said he was mentally-ill--exactly half of those who gave classifiable explanations, it was the distorted quality of his perception of reality and the inappropriate quality of his emotional responses that were uppermost in their thinking. These people were thinking, of course, of his anxiety and unhappy outlook on life. As they put it:

> (S) Well, because he has a more or less self-conscious attitude toward himself. (C) That's about all I can say--self-pity and anybody that crosses him brings on his anger.
>
> He's frustrated and certainly isn't happy, worrying about himself all the time.
>
> Because he shouldn't be touchy about little things, since he has a good job and doesn't have to worry about tomorrow.
>
> Because he's always looking for trouble and brooding or worrying over things he cannot rectify.
>
> Well, when someone acts like that--all bothered about little things--he's just not right.
>
> Excessive worry is a sign of mental disorder.
>
> He worries when there's nothing to worry about.
>
> He worries about everything. (C) People who are all right don't worry about <u>everything</u>.

A secondary consideration leading to the conclusion that "Brown" was mentally-ill was the feeling that emotional responses of this order belonged to the realm of the mental--either the emotional turmoil caused mental illness because the locus of the conflict was the mind, or no more substantial causes

could be produced to account for the behavior. This approach, used by about a quarter of those who explained why he was mentally-ill, is typified by these remarks:

> Mental illness is brought on by worry.
>
> The worry and not sleeping is bound to affect his mind. It puts him under a strain,and your mind can't stand that.
>
> That business of worrying--and apparently, about nothing--is definitely making his mind sick.
>
> Because his moodiness and touchiness is coming from an attitude of mind.
>
> Simply because the cause of it is a mental condition not a physical one.
>
> Something must have gone wrong with his mind. (C) Well if he ain't hurt or sick, it must be mental trouble to make him act this way.

Finally, much smaller groups considered his weakness of character, the uncontrolled quality of his behavior, his impaired ability to function efficiently and the general deviancy of his behavior from other people's in concluding that "Brown" was mentally-ill:

> Weakness: It's a mental case because it's mental weakness. If he was strong, he'd be able to stop worrying about trifling things. Any normal person should be able to erase experiences of the past and have an open mind for the future.
>
> Lack of control: He acts like he don't have good sense, worrying all the time and not sleeping at night. He don't have much control over his thinking.
>
> Impaired functioning: He can't rest, he worries all the time, so he's tired and cross and can't do his work right or enjoy life.
>
> Deviancy: He is acting like an abnormal person. (C) Most people aren't like him.

All of these were, however, minority opinions, since less than a fifth of the public regarded "Brown's" reactions as an instance of mental illness. In contrast, five main lines of reasoning supported the majority's conclusion that he was not mentally-ill. (See Table 28.) Most frequent of these was a

denial of the deviancy of "Brown's" behavior by about two-fifths of those who gave classifiable reasons for their decision that he was not mentally-ill. This argument generally took the form of asserting that "Brown's" emotional problems were common, if not unusual, among people today and, by this very frequency could not be classed as mental illness. Less often, there was positive approval of "Brown's" personality trends. "Brown's" description had, of course, been intended to suggest "the neurotic personality of our times,"[26] and these people were, in effect, saying that the

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[26]Karen Horney, The Neurotic Personality of Our Times. New York: W. W. Norton and Company, 1937.

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characteristic, modern neurosis was too much the norm of the culture to be considered illness:

> Most of us are like him.
>
> It's natural to worry when things don't go right. One wouldn't be natural, if they didn't. (C) All of us have these little disturbances.
>
> It's just the general run of the public to worry.
>
> If everyone like this were mentally-ill, a great many would be ill.
>
> I don't think that's a mental illness; he's just an ordinary guy to me. (C) I just think anybody would act like that when they're nervous and tired.
>
> We all worry to some extent, and, as far as snapping back at people, a guy has to have a certain amount of snap to get along.
>
> He is a very honest, conscientious type, or he wouldn't worry.
>
> To me, if he was mentally sick he would do more extreme things.

Each of the four other main lines of thought were used by about a fifth of those who gave classifiable reasons for saying he was not mentally-ill. In one version, "Brown" was regarded as responsible for his own difficulties or, at least, capable of remedying them himself, and, therefore,

not mentally-ill. In an opposed school of thought, the causes of "Brown's" behavior were outside his control, and he was, therefore, not mentally-ill. There was sometimes the implication that "Brown's" behavior was reasonable under the circumstances; sometimes, that it would vanish when the causes ceased to operate; and sometimes, that he was not to be held responsible for his reactions. These two opposed views of the relation of the nature of causes of behavior to its status as mental illness are typified by these comments:

> Responsibility: He just don't try to overcome his shortcomings and try to get along with people. There is nothing wrong with him that he couldn't correct by himself, by using a little willpower.
>
> He should help himself by clearing his conscience. He will never be happy until his conscience is clear. (C) He should go to some good friend--one he could trust--or a confessor and tell what he has on his mind.
>
> He needs to take an interest in others and not think about himself.
>
> Because he knows what's wrong with him and he knows what to do about it. He doesn't need a doctor, and that wouldn't help him.
>
> Lack of responsibility: I think he is sick physically, and that gives him a gloomy outlook.
>
> People have off-moments when they're irritable and out of sorts and say "what's the use of going on." The next day they feel different. (C) It's your physical condition lots of times. He could have heartburn or indigestion.
>
> He seems like a common, ordinary person. (C) He'd be O.K. if things straightened out for him.
>
> I'd call that a domestic illness. (C) It comes from his family life.
>
> Because I believe he could have been helped when he was a child.

Another point of view stressed only the ease with which "Brown" could secure relief from his symptoms, without concerning itself with

the original causes of or final responsibility for his behavior:

> He isn't mentally-ill; he needs a doctor, but a medical doctor.
>
> Proper rest and food could stop his touchiness and insomnia.
>
> A doctor could probably help him, but probably anybody who sat down and talked to him could, too. (C) Anyone that he likes--a brother, a friend.
>
> He just needs someone to bolster his courage.

Finally, people noted that he was able to function adequately or even successfully with no noticeable intellectual impairment and no danger to society:

> He wouldn't be able to hold his job if he were mentally-ill.
>
> He's able to get along in his work.
>
> He's only dissatisfied; he can function as a normal person in society; he doesn't break the laws or get violent or anything.
>
> Mental people usually are completely blank and can't carry on like normal people. With him, his mind's all right; he just isn't sure of himself.

Considerations much the same as those which led to the conclusion that "Brown" was not mentally-ill also influenced the majority of those who called him mentally-ill to regard his mental illness as not very serious. (Table 30.) The emphases differed, of course, the major reason for saying a mental illness was not serious being, as usual, the ease with which it could be corrected--by himself, by psychiatry, by amateur associates and so on--or even the lack of any necessity for treating it. Beyond treatment, however, people decided that "Brown" was not a danger to others, that his everyday performance was not seriously impaired, and that his symptoms were commonplace. The smaller group who took "Brown's" mental illness seriously essentially contradicted these assertions: "Brown" was

or might become dangerous to others and was, already something of a nuisance to them; his health and life were or might be seriously affected; his illness might develop into psychosis or something else not so common and not so easy to cure. (See Table 29.) The discussion went like this:

Treatment

Not serious: He can snap himself out of that.

He could stop that worrying, if he'd get hold of himself.

All he needs is to get some hobbies.

He could be helped by a psychiatrist or by analyzing his own self or a friend might be able to make him see his faults.

A good psychiatrist would straighten him out in a very short time.

An intelligent friend or wife could talk to him and make him snap out of it.

He'd smarten up fast if people didn't give him his own way a couple of times.

If he'd slow down and not work so hard, he'd be O. K.

A lot of it is his nerves. (C) He just may need rest and a change of scenery--get away from it all for a while.

He'll get over it as soon as he gets work that is suited to him; or whatever it is that is bothering him, adjust that.

It's something that could be worked out, but damned if I know how.

It can be corrected before it gets serious. (C) It's nothing that treatment wouldn't help.

Serious: It may lead to something worse if not tended to. (C) He can be pacified by apologies and humoring him.

It could become very serious if something isn't done to correct his condition.

A man in that condition sure needs to see his doctor.

If he doesn't get better soon, he'd get to a stage where he never would.

Social Implications

Not serious: At this point, he doesn't seem to be the type that would kill.

He isn't violent, so he isn't serious in his mental disturbance.

Not too much so, because his anti-social actions are mild. (C) He won't worry other people in a big way.

Serious: Well, when he is in one of these grouchy, ill-tempered ways, he might hurt someone.

People like him are dangerous sometimes.

Well, I say it's serious because I find that when you lose sleep you don't give the people you work for a good day's work.

He makes it rough for everyone he comes in contact with--at work and at home, too, I'll bet.

Personal Implications

Not serious: It doesn't bother him doing his job well, and he must get along with people somehow.

He's able to work and go on and do things he should do. If he had much of a mental disease, he couldn't do that.

Serious: He could even provoke someone so much that they'd hurt him.

Hot temper is dangerous because it may cause death at any time from heart or high blood pressure.

From all this mental sickness and worry, he might get stomach ulcers.

If a man can't sleep and can't get along with people, his life is going to be miserable.

Well, he's suffering. (C) He's worried and unhappy and not enjoying life.

He'll lose his friends and, maybe, his job, too, if he's always nasty like that.

Mildness

Not serious: Lots of people have that same condition.

His reactions aren't too different from other people's.

He can go on this way for years and never become any worse, or, in time, it may even straighten itself out.

I think it might cure itself; he might completely change. He might get a different outlook on things in a short time.

Serious: At the rate he's going, it will drive him completely insane.

He'll be completely insane, if he keeps on like that.

He could crack up completely.

I believe that any type of mental illness is serious and may develop into something like insanity soon.

If he doesn't stop worrying about himself all the time, he will become so absorbed in himself that he couldn't grasp things or ideas for future life.

Because it will get bigger. Things like that always do.
(C) It could be the beginning of a nervous breakdown.

If it isn't stopped, it could grow on him. Those things do grow on people.

The general tenor of popular approaches to "Brown" was not overly concerned. Among the majority who did not perceive mental illness in his difficulties, people were almost as likely to assert or imply that no counteraction was needed as they were to suggest the kinds of actions needed. (Table 31.) Insofar as people did see "Brown" as an action problem other than mental illness, they regarded it, first, as a practical problem which could be remedied by altering the unpleasant job, financial or home conditions that were creating his symptoms; second, as a moral problem to be remedied by "Brown's" altering his own attitudes or exercising self-control; and, third, as a minor physical condition to be cleared up by rest, change of diet and the like.

This tendency to minimize "Brown's" problems was in sharp contrast to public concern over the violence of "Frank Jones" and the alcoholism of

"Bill Williams," for both of whom recommendations for action far outstripped denials that counteraction was needed. "Brown" seemed more of a problem to the public than did the quiet withdrawal of "Betty Smith," or, as we shall see, the preoccupations of "Mary White," both of whom were treated as not yet quite adult. "Brown," on the other hand, was a mature, responsible, married man, but his behavior was not acutely anti-social and was, therefore, not a public problem. Unlike "Brown," the behavior of the other two men and the delinquencies of a boy like "Bobby Grey," to whose problems we now turn, posed obvious social threats and were not to be glossed over.

The Story of "Bobby Grey"

With "Bobby Grey," we turn again to popular approaches to anti-social behavior--this time, to stealing, truancy and other disciplinary problems in the behavior of a twelve year-old boy, in contrast to "Frank Jones'" violence and "Bill Williams'" alcoholism and family neglect. This conduct disturbance was seldom defined as mental illness, although, when it was, people generally took a serious view of it. "Bobby Grey's" mental illness was the only one in addition to the illnesses of the two adult males whose behavior had serious social consequences that was deemed serious by a majority of those who defined it as mental illness; and, as with "Jones" and "Williams," it was called serious just because of its social implications. But, only one person in seven defined "Bobby" as mentally-ill, while about half (49 per cent) said there was "nothing wrong" with him and 37 per cent found something other than mental illness wrong. (Tables 12 and 15.)

Despite disagreement about whether or not "Bobby's" behavior was

problematical, the two groups who did not view him as mentally-ill were fairly well agreed in the large as to the category of human behavior to which they assigned him. Roughly two-thirds of those who did not call him mentally-ill regarded him as an instance of personality or character, with about one-third using morally-censoring formulations and two-thirds characterizing him more neutrally. This division placed "Bobby" second only to the alcoholic in the extent to which his behavior was disapproved of. The major alternative formulation of "Bobby Grey's" problems saw him as responding to his immediate circumstances, the implication being that his behavior was entirely situationally-bound and would automatically alter if the precipitating circumstances were altered. But even here, roughly a fourth deplored his response. In addition, there were four per cent who saw "Bobby's" behavior as a normal stage of development through which all children or, at least, all boys passed. (See Tables 16 and 17.)

In line with this tendency to define "Bobby's" behavior as actually or potentially transient--an approach that was used more frequently with him than with any of the other examples, popular interpretations of "Bobby" incorporated psychological elements less often than in any other case. (Table 18.) And, where psychological depictions were made, there was less agreement about "Bobby's" main trends than for any of the other examples.[27] As may be seen in Table 19, 22 per cent characterized him

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[27] Part of this low frequency is attributable to the fact that "Bobby" was the one instance in which the description read to the respondent did not, itself, contain psychological elements. In the other examples, the categories of description with highest frequencies were generally rephrasings of the description which had been given.

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in terms of specific fears or motives, chief among which were a craving

or desire for the things he stole, a craving for excitement or love of adventure and a fear of punishment motivating his lying. (See Table 21.) Nineteen per cent described general trends which, essentially, characterized his behavior in terms of a "blaming-excusing" dimension, with six per cent defining him as delinquent or evil, seven per cent, as bad or naughty; three per cent, as lively or mischievous; and three per cent as experimenting or reality-testing.

Beyond these rather special approaches, 13 per cent saw "Bobby's" behavior as motivated by a desire to attract attention to himself or to impress his contemporaries; six per cent, by his resentment or rebellion against others and a desire to retaliate; and four per cent, by egocentricity. Low as these frequencies are, they were, nevertheless, the categories most frequently applied to "Bobby." Here are some concrete examples:

Attention-seeking: He's just showing off. (C) It's just natural for boys like that to show off. (C) If some older boys dared him to do something, he'd think he was a coward, if he didn't do it.

He wants to be the leader of the gang of kids he plays with, so this is one way to impress them.

They sometimes figure it's one way to get attention. (C) He wants attention, so he does these things to be a big fellow.

He knows he gets attention when he does these mean things, and I think that's why he does them.

Desire for things: He wants things that maybe he's denied, so he gets them anyhow.

A desire to have things he hasn't got; that's all it is.

It's all from wanting things he can't have. (C) He sees the other kids have them and he wants them too, so he just takes them.

Desire for excitement: He's just got a thirst to do those things, for the excitement that's in them.

I think it's a damn-fool kid doing a smart-aleck stunt and getting a kick out of getting away with it.

Maybe the kid just started to look for excitement and that's one way to find it. He wants thrills and gets it from stealing.

Fear of punishment: Well, his lying, that's because when he told the truth they probably gave it to him. The easiest way out was to lie.

Maybe he lies because he's afraid he's going to be punished.

He lies because it is easier to lie than to explain why he did this or that. He fears his parents.

Retaliation: His elders never praised him when he did good things, so now he might want to show them that he can do bad things.

They're probably treating him like a baby, so he's become defiant.

He's fighting back against something, getting even with them. He resents them, and doing these bad things would be his outlet for resentment.

Egocentricity: He's spoiled; he knows he isn't going to be punished, so he does as he pleases.

He's spoiled and just wants his own way about everything.

He's always been spoiled, given everything he wanted, and can't see why it should be any different.

Blaming-excusing: It seems to me he's a pure degenerate.

He's a criminal type, even at his age. (C) He thinks he can outfigure the law.

He's one of those bad types that don't want to do any good.

Why, he's just like all the kids around here--bad devils.

(S). It's just meanness. (C) Nothing happened to cause that; it's just the mean kid in him.

> He's just mischievous, acting like any child, always up to something.
>
> At that age, they try to be smart and see what they can get away with.
>
> All kids, good or bad, try anything once just for the experiment and, if not corrected, keep on doing it.

These psychological depictions of "Bobby" varied only slightly among the three groups who classified him as mentally-ill, problematic or non-problematic, with the exception that the extreme view of him as delinquent or evil was most concentrated in the group who diagnosed mental illness, while the less extreme degree of blame and, particularly, the justifying or excusing characterizations were more frequent in the group who saw him as non-problematic. (Table 21.)

But, if attempts to characterize "Bobby" psychologically were relatively infrequent and diverse, causal explanation of his behavior was the opposite. "Bobby's" behavior was explained by 86 per cent of the public, a higher proportion than that for any of the other examples, and these explanations concentrated on a relatively small number of causal patterns. (Table 22.) Since "Bobby" was presented as a child, it is to be expected that discussion of the causes of his behavior centered primarily around his relations with his parents. Two-thirds of the public talked about the methods that had been or were being used in rearing him, while only 19 per cent explained "Bobby" without reference to parental practices. (Fourteen per cent did not offer causal explanations.) These parental errors in child-rearing can, as usual, be divided, on the one hand, into the overly-depriving and the overly-indulgent, and, on the other, into those which employed the logic of direct equivalent conditioning and those which were more broadly

based.[28]

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[28]For "Bobby Grey," the following additional categories, shown under interpersonal relationships in Table 22, were classified as direct, equivalent conditioning: "Others failed to provide sufficient spending money"; "Others failed to provide other material things needed"; Others failed to teach moral standards, inculcate or develop character"; "Others failed to exercise discipline, control, supervision." All other interpersonal categories were assigned to psychodynamics, with the exception of the following categories, assigned to external circumstances: "Others (with whom person compared himself) were or appeared to be superior, better off"; "Relationships with loved ones have been involuntarily disrupted, terminated"; "Relationships with others were lacking, absent."

Most frequently mentioned as a parental error was their apparent failure to exercise sufficient supervision and discipline over "Bobby's" activities. Among people who referred to the area of parent-child relationships, 32 per cent said things like:

> Failure of the parents to punish for the wrong things he does.
>
> Maybe from a small child the parents never did check behind him and see to him doing the things they told him to do.
>
> He hasn't been corrected about these things soon enough. His parents evidently have not taken enough time checking his actions and whereabouts.
>
> His mother and father are too loose with him, so he's acting smart in front of his friends. (C) They haven't got the power to make him mind, and that's their fault.
>
> A lot of that comes from the parents' not making them mind. They're not taking an interest in their children.
>
> It's habit-forming, and his home atmosphere could not have been too well supervised or they would have known that at a younger age. (C) He never learned to obey as a child.

Quite consistent with this approach were 18 per cent who felt that "Bobby's" parents had neglected his moral training, failed to teach him that lying and stealing were improper. They said:

> He was brought up wrong. (C) His parents, when they caught him in his first lie, did not explain that he shouldn't steal or lie.
>
> He's been negleted by his parents. (C) His parents haven't set the right path for him to walk. They've just let him alone, and he's growing up to be a rogue.
>
> His parents are responsible for his actions; they have probably been too busy with something else to give this child the amount of training he should have had. (C) He's growing up not knowing right from wrong.
>
> Maybe it's the home again. (C) Something lacking in the teaching of responsibility and the teaching of what's right and what's wrong.

These two categories together--the failure to teach moral standards and the failure to exercise enough discipline to enforce them--were mentioned by 46 per cent of the people who discussed the role of "Bobby's" parents in his problems. In both versions, "Bobby's" misconduct was the result of lack of direct conditioning to honesty, and this omission was generally regarded, as was apparent in the excerpts above, as a form of parental negligence or neglect. From the popular standpoint, these assumed parental practices, therefore, represented rejection or lack of parental concern and were deprivational in effect: "Bobby's" parents had so little interest in his well-being that he was deprived of character training, and his conduct reflected the lack of it. At the same time, however, such practices represented an absence of restraints placed on "Bobby" and, consequently, achieved quite the same results as positive over-indulgence or over-permissiveness on his parents' part.

Because of its dual character, this form of direct conditioning by lack of conditioning contrasted markedly with the second major version of "Bobby's" difficulties with his parents, which dealt solely and clearly with deprivation. In this account, "Bobby's" conduct was, again, the result of direct, equivalent conditioning: He stole because his parents

failed to give him playthings or spending money to buy the things he wanted. This explanation of "Bobby's" conduct was employed by 26 per cent of the people who examined his relations with his parents, with two-thirds stressing his need for spending money or a regular allowance and one-third focussing on the toys he was deprived of.[29] For instance:

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[29]It should be mentioned that all these instances represented deprivation. Where "Bobby's" parents were described as economically unable to give him spending money or as many toys as his playmates had, the causes of "Bobby's" behavior were classified as external circumstances.

> His parents can be to blame. (C) They could keep things they can afford in life away from him.
>
> Maybe he's denied things he wants, so he gets them anyhow.
>
> His parents probably don't give him any spending money.
>
> Maybe his parents were very short with him; that is maybe they give him very little allowance for himself to spend the way he wants to.
>
> It's wanting things he can't have. (C) He's probably denied everything at home, no money, no opportunity to earn it around the house, like some parents do.

Direct, equivalent conditioning thus bulked large in "Bobby's" relations with his parents. If duplications are eliminated, where people followed both the lack of moral training and deprivation of material possessions approaches, two out of three dealt with parent-child relationships in this direct, equivalent way, at least in part.

The third approach to the errors which "Bobby's" parents had made or were making went beyond the narrower confines of direct conditioning to stress the generally harsh, rejecting, repressive policies of his parents. Exactly a quarter of the people who dealt with parental relations at all interpreted "Bobby's" behavior as the result of lack of love and emotional security, on the one hand, and overly-rigid, authoritarian discipline, on the other, with both these factors mentioned about

equally often. These people said:

> His trouble stems from not feeling secure enough in his home.
>
> Maybe his home was comfortable enough, but the parents might not have given him love.
>
> I think his parents are definitely too strict with him. They probably haven't given him the proper affection or feeling of security.
>
> His parents were too strict with him, and now he's showing them up.
>
> I'd say it was more the parents than the boy. Perhaps he hasn't been trusted or been given freedom enough. He's fighting back against something.

The final major version of parental errors took the line that "Bobby's" parents had been or were overly-indulgent and had succeeded in "spoiling" their child. Some 10 per cent said:

> Maybe he's the only child in the family, and he was babied too much.
>
> It could be the parents' fault by allowing him to have his own way. (C) They might not have wanted to have him cry.

One or more of these four leading accounts of the role of "Bobby's" parents in his difficulties was advanced by 88 per cent of the people who turned to parental influences in interpreting "Bobby," so that 58 per cent of the American public or two-thirds of the sub-portion who attempted any explanation of "Bobby" at all were represented by these approaches. The remaining small group who talked about parental influences in terms other than these was divided, roughly, among five per cent who simply mentioned his parents without specifying the nature of their acts, two per cent who felt "Bobby" had taken over directly the moral standards and conduct of his parents, and five per cent who mentioned a wide variety of other possible actions, almost all of them hostile, rejecting and repressive in effect.

In addition to his parents, "Bobby's" playmates were the only other persons who were frequently seen as playing a significant role in his delinquencies. Some 29 per cent mentioned his playmates, usually in the context of their setting "Bobby" a bad example or leading him astray. Of people referring to his playmates, 86 per cent were thinking of their direct teaching and influence, while 12 per cent thought of his playmates as forming an external criterion or standard by which "Bobby" determined the inadequacy of his possessions and his right to have more, and six per cent referred to a variety of conflicts and frictions in "Bobby's" relations with other children which led him to defiant behavior. "Bobby's" playmates most usually entered into the sequence of events causing his behavior as one factor in a more complex situation involving his parents. Thus, a fifth of those mentioning playmates said that their influence, in the absence of adequate parental supervision, accounted for his behavior; or, similarly, in 10 per cent, it was his playmates' encouragement to steal in the face of parental refusal to give him things he wanted; or, for five per cent, his playmates' having possessions his parents denied him. All told, his playmates were mentioned in connection with his parents 60 per cent of the time, so that only for 11 per cent of the entire American public were "Bobby's" playmates the sole or major source of his conduct. Typical of comments about "Bobby's" playmates were:

> He might have learned it from his friends. If his friends get away with it, he'll try it, too. Children copy one another.
>
> Bad company, more than likely. He might just be playing with other boys who steal for fun. Older boys will get young ones to do their stealing for them.
>
> It could be the environment of other kids that he plays with. (C) His parents weren't strict enough, and he got in with the wrong fellows.

> He's on his way to becoming a juvenile delinquent. (C) Chances are it's his companions, bad associations. It's the parents' fault really. (C) The parents might go to work and leave children with a maid or no supervision at all. They see too many gangster movies and start playing with the wrong children.
>
> His family could be at fault. They probably don't supervise his company, and he's probably just gotten in with the wrong crowd.
>
> It could be that he's learned it from older boys. (C) His parents may have just let him run around and go with the wrong kind of boys.

The two most frequent characterizations of the source of "Bobby's" difficulties were, then, his parents' failure to teach and enforce moral standards, mentioned by 30 per cent of the American public, and his association with other children given to lying and stealing, mentioned by 25 per cent, with one or another or both of these influences mentioned by 48 per cent of the public, well over half of those who offered causal explanations. The third most frequent single theme--that his parents provoked his stealing by unnecessarily depriving him of material possessions--was mentioned by 17 per cent of the public and, together with the two more frequent explanations, constituted the major emphases within the category of direct, equivalent conditioning. Some one or combination of these three conditioning lines of interpretation was applied to "Bobby" by 55 per cent of the American public, roughly two-thirds of those who offered causal interpretation. When the other manners in which "Bobby's" parents or playmates were conceived to have influenced his behavior are added to these direct conditioning approaches, 77 per cent of the public incorporated at least one of these modes of explanation into their accounts, and they constituted 91 per cent of the group who did attempt to explain his behavior.

The emphasis in popular causal interpretations of "Bobby" was, thus, on direct equivalent conditioning in his parental and peer relationships, with secondary attention given to broader aspects of the psychodynamics of "Bobby's" relations with his parents.[30] Other types of causal

[30]The first of these categories, conditioning, was occasionally reinforced by references to the influence exerted by environment, about four per cent of the public mentioning the corrupting effects on children of the glorification of crime in mass media like comics, radio and TV programs and movies.

factors seldom entered the discussion except as alternatives to or elaborations of these major factors. While 16 per cent did mention such causes as organic factors, innate temperament and external circumstances, only seven per cent relied on any or all of them exclusively. The category of external, environmental causes, for instance, where eight per cent of the public were classified, consisted about equally of situations in which "Bobby's" playmates, by their very existence, confronted him with invidious comparisons because of their economic advantages and situations in which his environment was generally uncomfortable because of immediate frictions in his play, school and home relationships. Factors like these almost always represented complicating details, and only two per cent of the public introduced them independently of conditioning and psychodynamics. The only other causal category which received any significant mention was that which regarded "Bobby's" behavior as innately determined. Almost eight per cent used this hereditary-constitutional possibility, usually as an alternative to more immediate causes--"If his parents aren't doing anything wrong, then maybe he was just born this way." And, it is noteworthy that, while only three per cent of the populati n mentioned the possibility that "Bobby" was a kleptomanic, they were 11 per cent of the

group using innate determinants.

The reliance on narrowly-conceived conditioning factors to explain "Bobby" was most marked in the half of the population who saw nothing wrong with him. In this group, direct, equivalent conditioning was used by 61 per cent--close to three-quarters of those who gave any causal explanation, and conditioning types of causes were mentioned about twice as frequently as more general psychodynamic relationships. (Table 23.) As has been pointed out in connection with some of the other examples, the essence of the direct conditioning approach is that it relates effects to causes which are identical in manifest content, so that the outcome appears as the logically expected result of the cause. It is for this reason that conditioning loomed so large among people who felt that nothing was wrong with "Bobby"; that is, his behavior was that to be predicted under the postulated circumstances, and it almost goes without saying that the conditioning approach was most common where the entire situation was summarized as "Bobby's" response to his current circumstances. (Table 24.) At the other extreme, the seventh of the population who called "Bobby's" behavior mental illness were least likely to use conditioning causes, and, in fact, interpreted him in terms of broader psychodynamics slightly more often than they looked for equivalences.

This contrast in causal explanations between the group defining "Bobby" as mentally-ill and the group which defined him as non-problematical was almost entirely a function of the variation between them with respect to the two most frequently mentioned causal patterns: parental failures in teaching and enforcing moral standards and the bad example of his companions. Each of these conditions were mentioned about twice as frequently by people who said there was nothing wrong with "Bobby" as by people who

said he was mentally-ill, and there were no large differences between them for any of the other specific themese.

This large association between a conditioning type of explanation and a tendency to accept the results of such causes as non-problematical suggests immediately the reasoning which was called on to explain the conclusion that "Bobby" was not mentally-ill. Of four main lines of thought which entered into that judgment, the most frequent returned to a consideration of the nature of the causes of his behavior. (Table 28.) About 31 per cent of those who said "Bobby" was not mentally-ill--close to half of the people who advanced classifiable reasons for this position --did so because they exonerated "Bobby" of responsibility for his behavior. The most frequent version, employed by 18 per cent, explicitly blamed others for the way he acted, and those others were, 97 times out of 100, his parents. An additional seven per cent attributed "Bobby's" behavior to circumstances outside his control and, again, were in three out of four cases, referring to the actions of his parents, though without expressly assigning them moral responsibility for "Bobby's" conduct. In still less frequent varieties of this line of thought, the conduct patterns were held to be too ingrained to be modified at this point, or "Bobby" was regarded as too young to permit the kind of assessment of responsibility needed to conclude that he was mentally-ill. For example:

> If it wasn't for his parents he wouldn't be doing all this.
>
> His parents have shaped his life.
>
> The fact that his parents have not taught him a sense of right and wrong does not show an abnormal functioning of <u>his</u> mind.
>
> If his parents had taught him right, he'd have been all right in the first place.

I don't think it's in the mind. It's just that he wants those things and his parents won't let him have them.

It's just the company he keeps and the stuff they see and hear. (C) All the crime stories and movies give them ideas.

He was just born like this; he can't help it.

A child is not responsible for what he says or does urtil they reach a certain age.

In the second most frequent way of looking at "Bobby's" problems, 24 per cent of those who said he was not mentally-ill (about a third of those who explained their position) reasoned that his behavior could be corrected by means of every-day, commonsense measures. These suggestions were divided between six per cent who felt that spanking "Bobby" would straighten out the situation and 19 per cent who felt that less drastic changes in the way people dealt with him--primarily firmer training and supervision--would correct his difficulties. These corrective steps were recommended, about three quarters of the time, in instances where his parents were involved in the causes of his behavior, but this approach differed from the preceding one in that it was the means by which the problem could be corrected rather than the ultimate responsibility for its creation that seemed to determine the diagnostic judgment. In fact, the two approaches seldom occurred together: only five per cent of those who said "Bobby" was not mentally-ill included both lines of reasoning in their explanations. The decision that a problem which could be resolved by application of hairbrush, discipline or amateur psychology was not mental illness is typified in these comments:

His mother and father could cure him of that lying and stealing too, if they whip him good every time they catch him at it.

> He just needs a good whipping and then more patience and cooperation from the parents and other people who come in contact with him to put him on the right track.
>
> It's a case of checking on his associates, having a talking-to with him, and maybe depriving him of some of his privileges and he'd be all right.
>
> He's just like any kid. He just needs somebody to talk to him and scare him.
>
> If they start now to give him the right training, he'll be all right.
>
> He needs thoughtful handling and care to prove he is loved and needed and wanted at home, and all these things will clear up.

The two remaining reasons for regarding "Bobby's" behavior as something other than mental illness were that the behavior was commonplace, occurred too frequently to be considered abnormal, mentioned by 16 per cent, and that it was transitory and would correct itself without any special efforts, mentioned by 11 per cent. For seven per cent, these two lines of reasoning were merged into the view that it was a temporary stage of development which all or most boys went through, and "Bobby" would "grow out of it" as he matured. For instance:

> I know he needs help, but it isn't mental. (C) Because there's millions of others like him. It's a human failing not a mental illness.
>
> Kids at that age all steal.
>
> When boys are that age, they often get into those bad habits, but they grow out of it usually.
>
> I think it's just a phase of growing up; every child goes through it.
>
> He'll be all right when he gets it out of his system. (C) As he gets older, he'll get over it.

For the small minority for whom "Bobby's" behavior was mental illness, on the other hand, it was mental illness primarily because it

did appear to be deviant behavior and, especially, because it appeared to be deviancy either in an anti-social, criminal direction or in the direction of compulsive, uncontrolled, irrational action. (Table 27.) Fifty-four per cent of the group, roughly two-thirds of those who gave interpretable explanations of why they considered "Bobby" mentally-ill, gave reasons of this order, as illustrated by these remarks:

> He steals and that's not normal.
>
> He's doing things already that are against the law.
>
> He's going by standards he's set up for himself rather than standards society sets up for him.
>
> By his coming from a comfortable home and having what he needs, and then stealing anyway.
>
> Yes, if he takes things he don't even need.
>
> He knows stealing and lying are wrong, but can't seem to stop himself from doing it.
>
> Because his actions are not normal. (C) A normal child would be like other boys and not be doing these things.
>
> Just because of his unusual conduct.

In addition to those who stressed the deviant qualities of "Bobby's" behavior, the next most frequent explanation of a diagnosis of mental illness in his case was the inability to establish a causally-adequate chain of events unless mental illness was postulated as the initial point in the process. Mental illness was diagnosed by 11 per cent of those who said "Bobby" was mentally-ill just because the behavior did not appear to them to be related to any causes they could think of with the kind of congruence between symptoms and causes that they tended to look for; the behavior was mental illness to them just because there was, essentially, no satisfactory causal explanation of it. They said:

> Something has to cause it. It either has to be his upbringing by his parents or else it's mental illness.

> He must have. His homelife is good and all that, and I can't see any reason to make him act like that, unless he has something wrong with his mind.

> A kid that age would have to be mentally-ill to do all of that stuff.

Much more decisively than it was a determining consideration in deciding "Bobby" was mentally-ill, the anti-social, criminal implications of his behavior were singled out as a reason for calling his mental illness serious. (Table 29.) Well over half (58 per cent) of those who called his illness serious explained their decision with remarks like:

> He'll become a thief if not retrained.

> If it's not taken care of now, he'll just grow to be a bigger crook.

> If not corrected, he could drift into being a bad character, an outcast or a criminal.

> Because his thieving might get to the point where he'll steal big things and have to be put in jail, which means it'll cost the tax payers more.

Beyond this emphasis on the feared social consequences of "Bobby's" disturbance, the seriousness of his illness turned on the need for dealing with his condition and its possible disruption of his own life, as in these comments:

> Good treatment now could cure the whole family, but, without it, the boy's whole life could be damaged.

> It can be very detrimental to his entire life.

> He's just at the age where the way he's handled now can decide how the rest of his life is going to be.

For the minority who did not view his illness seriously, the primary consideration was, as always, the presumed ease with which it could

be corrected. (Table 30.) Of those who did not take it seriously, 31 per cent regarded it as an illness that would pass of itself, without special attention, using, in fact, much the same logic as those who said it was not mental illness at all because of its transitory character. And 28 per cent felt it could be relieved by much the same kind of interpersonal effort to retrain "Bobby" as those who said it was not mental illness because it was amenable to such treatment. For instance:

> Self-correcting: He may outgrow it. Lot's of people are that way and outgrow those diseases.
>
> Because they usually outgrow it.
>
> Retraining: It can be easily cured without drastic steps. He just needs someone to get him interested in other activities. He needs to be kept busy.
>
> Not for a boy his age, no. He's young and can be taught. A different environment and teaching of a child that young can overcome that mental illness.

The problems of "Bobby Grey," with their overtones of present delinquency and possible more extreme future social consequences, seemed to the American public to call for immediate corrective action. Of those who did not call him mentally-ill, three-quarters introduced the need for ameliorative action into their comments (Table 31). He was, however, a child and, although twelve years old, was generally regarded as still highly malleable. As a consequence, over half the people who made any suggestions for correcting his behavior looked on the problem as a practical one of changing the conditions which were provoking his behavior, with the thought that his symptoms would vanish as soon as the external and interpersonal causes of his behavior were modified. And, in a somewhat similar fashion, a fifth suggested interpersonal steps to be taken by his parents as a solution to his problems. The only other way that

"Bobby's" problems were defined, to any appreciable extent, were in moral terms, disapproving and rejecting of "Bobby," although this approach was not generally linked, as it was with adult examples, to the conviction that he was capable of changing himself if he cared to. As the instance in which the need for action to be taken was most apparent to the American public, "Bobby" stood in sharp contrast to the last of these hypothetical persons, "Mary White," in whose story people were convinced that nothing requiring action existed.

The Story of "Mary White"

Despite her compulsive checking of door locks and gas stoves and her phobic avoidance of elevators, "Mary White" was a non-problematic person to the majority of the American public. Just over three-quarters of them found nothing wrong with her, while seven per cent said she was mentally-ill and 16 per cent found something other than mental illness wrong. (Table 12.) The small group who did classify her as mentally-ill identified her illness as non-psychotic, insofar as they used differential diagnoses at all, and less than one in five of them regarded "Mary's" syndrome as serious. (Table 15.) Of the six examples used in the study, "Mary White" was the only one for whom a majority said nothing was wrong, she was the least likely to be perceived as mentally-ill, and her mental illness was least often regarded seriously.

As with the other girl, "Betty Smith," "Mary" was viewed almost exclusively as a psychological type. (Table 16.) Aside from an occasional reference—by those who thought something was wrong with her other than mental illness--to her having a nervous illness, both people who saw her as problematical and people who did not discussed her as an instance of temperament or personality toward whom they were either non-critical or

positively approving. (Table 17.) In line with this emphasis on personality, all but five per cent of the public made either descriptive or interpretive comments on a psychological level. (Table 18.)

Two comments dominated these observations about "Mary White." On the one hand, 46 per cent repeated the description which had been given by commenting that she was afraid of or disliked elevators, and, on the other, 38 per cent reinterpreted the compulsive features of her symptoms by describing her as reasonably or excessively cautious, careful or conscientious. (Table 21.) As these high frequencies suggest, the popular tendency was to deal with the compulsive and the phobic aspects of her behavior as distinct, unrelated elements in her personality, rather than to advance more general interpretations that subsumed both of them. In the public as a whole, 71 per cent discussed both the compulsive and the phobic aspects of "Mary White's" behavior, but only 13 per cent approached them as an integrated whole, while 58 per cent dealt with each separately. (For the rest, 18 per cent discussed only the checking parts of her behavior; eight per cent, only the elevator phobia; and three per cent were unable to say anything about her.)

Along with this tendency to approach "Mary White's" symptoms in isolation from one another, people generally selected more concrete rather than more abstract interpretations. Thus, as over against the 46 per cent who said "Mary White" was afraid of elevators, there were 16 per cent who abstracted from this fear of elevators a fear of heights, a fear of closed spaces, a fear of falling or a fear of being hurt, injured or killed. And, either the concrete fact of her fear and avoidance of elevators or its next degree of abstraction into these other fears or phobias accounted for the descriptions of 91 per cent of the people who referred separately to

this part of "Mary White's" story. In speaking of her problems with elevators, people said:

> It might possibly be a fear she has of riding in elevators.
>
> Maybe the elevator just scares her.
>
> The elevator might be caused from some fear.
>
> She's probably just afraid of the elevator.
>
> She probably would rather walk upstairs than ride the elevator. (C) She probably doesn't like them.
>
> It could be a little nervousness that she don't want to ride an elevator. (C) She's nervous--just can't stand going up and down in an elevator.
>
> Elevators is more superstition than anything else. (C) Afraid that something is going to happen in one.
>
> It may be just a habit about the elevators. Maybe she's scared or something. (C) Maybe she's afraid the elevator will break and she'll fall.
>
> She just has a fear. (C) Maybe she's afraid of heights. (C) That's all I could say; I don't know what makes people afraid of heights, but they do have those fears.
>
> There's nothing wrong with people who are afraid of elevators. They just have a complex, claustrophobia, is the name. (C) They get nervous shut up in a small space.

"Mary's" checking of doors and gas stove was, as has already been mentioned, most frequently perceived as an exercise of caution on her part. Typical of the 38 per cent of the public who interpreted her behavior in this fashion are these comments:

> She is just using good sense, just trying to keep anything from happening. That ounce of prevention that is worth a pound of cure is what she is using.
>
> She just wants to be sure everything is done right, up to now--efficient. (C) Just checking on herself, she wants to be accurate.
>
> She believes in "safety-first." (C) She is cautious and certain that there's no trouble will follow.

She wants to be sure about her things. (C) Because she will know then that the door is locked. (C) Nothing, but she just likes to be sure in her own mind that everything is definitely all right.

She is keeping on the safe side from fire. The door-locking is to make sure no one will go in while she's gone away. (C) She's just very careful, I think. (C) Nothing I know of, except she's a very careful person.

She is just precautious, which is a good fault.

She just wants to be sure. She is a girl who wants things right and just keeps checking to see that it is right. (C) I don't think anything happened; she just started out being careful and just continues.

She's overcareful. (C) She just got started making sure everything is all right. (C) I don't know, many folks take on some little habit you can't understand why they don't stop it. (C) Nothing only she's just the kind who does the same thing over and over.

Beyond simple caution, 22 per cent concluded that "Mary's" checking was evidence that she was forgetful or absent-minded. For much smaller segments of the public, her need to check on her performance of routine tasks indicated that she was careless and inattentive in carrying out her duties, too hurried to remember what she had done, or too preoccupied with other concerns to recall such details. These factors might, in turn, directly account for her behavior, cause her to be forgetful, or lead to the adoption of a deliberate policy of double-checking. For example:

Forgetful: Seems like she is a little forgetful, in the first place. (C) She forgets, so she looks to see if the gas is off or if she locked the door. She just wants to be sure.

There is nothing wrong with her except forgetfulness. (C) That's why she's formed the habit of going back to see about the stove and door.

She's just a little absent-minded and feels, if she didn't go and look and see if the gas stove was lit, her forgetfulness may cause an accident, like a fire.

> She suffers from lapse of memory. (C) It's just a fault or habit that a lot of people have. She knows she has a short memory and don't trust herself to remember.

Careless: She is just careless about things, does not pay attention to what she is doing.

Hurried: She has too much to do and too much to take care of. She's not sure she's done it--it's that people are too much in a hurry, do too much at a time.

Preoccupied: She wants to make sure she checked everything, and, because she had other things on her mind, she forgot whether she did or not.

Carefulness, forgetfulness, haste, preoccupation, lack of attention or some combination of these psychological elements entered into the accounts of 78 per cent of those who discussed the compulsive aspects of "Mary White's" behavior separately from the phobic symptom.

In addition to these psychological trends and the enumeration of specific fears, there were, among the more frequent categories of psychological description, only two which tended to have a more generic quality. A fifth of the public concluded from either or both of "Mary's" major symptoms that she was an insecure or an anxious personality. These interpretations could, potentially, connect the two symptoms as diverse manifestations of a single basic emotional trend and were, in fact, used twice as frequently by people who had an integrated approach to "Mary White's" symptoms as they were by people who approached each symptom separately. Despite this tendency, these interpretations in terms of anxiety or insecurity were, nevertheless, primarily applied to one or the other of her symptoms rather than extended to both, as in these comments:

> She has a lack of confidence in herself, or she wouldn't be that way. (C) A person like that doubts themselves; they don't want to trust their mental thinking, or maybe they can't trust it, so they do everything twice.

She just doesn't trust herself, so she's extremely careful about everything she does.

She's afraid of things, on the nervous order; don't have confidence in modern, high-speed equipment.

She's a very timid, frightened person, underneath. (C) She worries that things might happen to her. (C) All kinds of things: fires, burglaries, elevator accidents; everything frightens her, nothing's safe.

The simplest account of "Mary White"--that she was a cautions, careful person, on the one hand, and afraid of elevators, on the other--tended to go along with the view that nothing was wrong with her. In particular, references to her being cautious, careful or conscientious were made by 44 per cent of those who said nothing was wrong with her, and this was their most common description of the compulsive features of her behavior, with only 16 per cent characterizing her as anxious or insecure. In the group who concluded that she was mentally-ill, however, only 13 per cent had described her as cautious or careful, while 34 per cent had perceived anxiety or insecurity in her behavior. Unlike most of the other examples, then, the way in which "Mary" was perceived had some influence on conclusions about whether or not she was mentally-ill. This contrast in perceptions affected diagnostic judgments, but was not their major determinant. People who saw "Mary White" as an anxious, insecure personality were over six times as likely as those who called her cautious or careful to classify her as mentally-ill, but, in absolute terms, 13 per cent and two per cent, respectively, called her mentally-ill. The large majority found nothing wrong with her, irrespective of their psychological insights about her, the proportions running from 60 per cent of those who perceived anxiety to 86 per cent of those who found her careful and cautious.

For over two-fifths of the American public, interpretive comments of the kind just reviewed finished the discussion of "Mary White." (Table 18.) Four per cent said she was careful "by nature" or inherited

a fear of elevators or explained her personality by postulating similar innate qualities, nine per cent were at a loss to suggest possible causes of her behavior or her personality traits; and 28 per cent never commented on non-psychological elements in discussing her. Where interpretation was carried further, the causes of behavior like "Mary White's" were traced primarily to antecedent, equivalent experiences. Of the three-fifths of the public who offered classifiable explanations of her behavior, 89 per cent employed the logic of direct, equivalent conditioning, and 81 per cent did so without reference to other possible causal lines.[31] For the population as a whole, then, 52 per cent relied on conditioning, at least in part; 48 per cent used it exclusively in accounting for "Mary White"; four per cent touched on other possible causal explanations in addition to conditioning, and eight per cent explained her without reference to conditioning. (Table 22.) Causes other than conditioning were, thus, rarely mentioned and were, about half the time, references to the innateness of the personality traits ascribed to "Mary White." Since other explanations were so infrequent, this discussion will concentrate on the typical explanations grouped under the heading of conditioning.

[31] For "Mary White," direct equivalent conditioning consists only of the categories shown under that heading in Table 22. Causes shown as interpersonal relations in that table were classified as external environment, when they referred clearly to her adult life, and as psychodynamics, in all other instances.

The nature of direct, equivalent conditioning as an explanation of human behavior is such that there must necessarily be separate explanations for separate symptoms. Conditioning, as used here, requires

that "Mary White's" repeated checking to see that her door was locked and her gas stove turned off be traced either to experiences involving the locking and unlocking of doors and the turning on and off of gas stoves or to experiences involving the most immediate social implications of unlocked doors and lit stoves--that is, to experiences involving thefts and fires. Her avoidance of elevators, on the other hand, must be connected either with experiences involving elevators or with experiences involving objects or connotations in the same general class as elevators --that is to experiences involving airplanes, stairways or closets, or, more generally, to those involving heights, falling, or closed spaces. Because the essential requirement of direct, equivalent conditioning is that the symptom and the experiences giving rise to it be identical in manifest content, all but three per cent of the people who used the conditioning approach were discussing the impulsive and phobic aspects of "Mary White's" behavior separately.[32] Accordingly, the development of compulsions and phobias must also be presented separately.

[32]The three per cent who used conditioning reasoning within an integrated approach were people who, for example, subsumed both the compulsive and phobic features under a more generalized fear of disasters which had developed from previous accidents or who saw in her symptoms a manifestation of some other personality trait which she had acquired by being trained to be like that.

First, then, "Mary's" checking of doors and stoves, where conditioning explanations were made by 92 per cent of those who explained it at all: Of those who employed this mode of explanation, a third related accounts that had complete equivalence. That is, her present checking was the result of a prior experience in which her own failure to check the door or stove produced unpleasant experiences. For instance:

> Maybe once she went away and left the stove on or left the door unlocked, and something may have happened, so she doesn't want it to happen again. (C) Maybe someone came in and robbed her house.

> Probably she went off once and left the gas stove burning and something burned up. Just to be sure, she got the habit of going back to look at it.
>
> It ain't enough to worry about. It just may be she left the fire under some beans once and ruined her stove and pot, and she's afraid it'll happen again.
>
> Maybe she had an experience in her younger life where she left the door open or left the gas on, and the house burned down.
>
> Well, if she forgot to turn off the stove once or forgot to lock the door and somebody got in and stole something, that would naturally make her more careful.
>
> Maybe she's gone off and left the gas stove burning and caused an accident.
>
> I imagine what makes her like that is she probably left the stove on once or twice and the door unlocked. She realized how dangerous it was, and it worried her. She probably said that she wouldn't let it happen again.

In addition to this exact duplication of cause and effect, about a quarter of those who explained "Mary's" compulsive checking by conditioning, used somewhat similar versions in which the responsibility for the accidents was not so clearly "Mary's" own negligence or the precautions omitted were not precisely the same as those she currently practiced. They adhered, nevertheless, to the general equation of "prior accident, present caution," as in these examples:

> At some time in her life, she has left something undone, and it has cost her something, and she's afraid something is going to happen to her again.
>
> I suppose, sometime she's been in a house that caught on fire or a house that was broken into because the door wasn't locked, so she's just cautious.
>
> Her family may have had trouble over some accident, and she is trying to keep it from happening again.
>
> She has been frightened in childhood by a burglar or a fire in her home.
>
> Maybe her home's been broken into or burned down before.

For another fifth, the conditioning experiences were not things which had happened to "Mary," at all, but simply her having heard or read about accidents which resulted to others who omitted precautions:

> Maybe she read about a fire or an explosion because the gas was left on; maybe she knew someone who had been robbed.
>
> She might have seen something or read something that went wrong because the gas wasn't turned off or the door not locked.
>
> It's possible that she has known or heard of a house burning or something happening because of lack of precaution.
>
> Maybe she's read so many terrible things about robberies and things that it's just made her overcautious.

And, for a final fifth, "Mary's" checking was the result of having been trained to take precautions:

> Her parents. (C) By asking her to make sure she had the lights off and the door locked, so now it's force of habit, and she never got over it.
>
> Maybe her mother always checked up, so she automatically does that too.
>
> She's been told so much to see if things are in order that she just naturally does it; it's a habit.
>
> She was taught to always check all things before leaving home.

The story of the elevator followed much the same lines, with 91 per cent of those who explained it turning to comparable conditioning experiences. For the largest sub-group--a third of those who employed conditioning explanations, "Mary's" avoidance of elevators was caused by pathological physical reactions to them. By implication, she had decided to avoid them, after she had learned from experience that riding in elevators caused her unpleasant physical sensations. This intervening logic was seldom spelled out, however; instead, people generally spoke as though the physical process involved operated automatically to make

it impossible for her to ride elevators. The quasi-physical version of conditioning sounded like this:

> Sometimes people can't ride elevators. (C) They get sick and dizzy going up on them.
>
> The motion of the elevator might make her sick.
>
> There's something wrong with her heart that causes her not to ride in elevators; it makes her sick.
>
> I've heard of lots of people who couldn't ride in elevators because they got a sick feeling or felt like the bottom of the world fell out or something.
>
> It could be the sudden start and stopping of elevators makes her sick to her stomach.
>
> The elevator business makes her swimming-headed; maybe her eyes are not strong enough.
>
> The elevator could make her sick, so she prefers not to ride in one.

For a sixth, her fear of elevators was a result of experiences in which elevators had functioned improperly, and she was hurt or frightened by the accident; while, for another sixth, the usual operation of elevators had been intrinsically frightening, especially at a younger age.

> Objective: Might be she was on an elevator when she had a scare. (C) Got stuck between floors.
>
> An elevator might have fallen with her on it.
>
> Maybe she was hurt on an elevator once.
>
> Subjective: Probably as a child, riding up and down in an elevator scared her and she's not forgotten it.
>
> Just phobias. (C) It might have been childhood environment. (C) Maybe she was frightened in an elevator the first time she rode one.
>
> The elevator is a childhood fear. She might have been forced into one as a child and was frightened. It made a deep impression and she can't get over it.

For still another sixth, the elevator phobia was a specific manifestation of a fear of some of its characteristics and was the result of experiences

which conditioned fears about falling, heights or closed spaces:

> The elevator is a complex. (C) Maybe she remembers some early experience of going up or down which was not pleasant. (C) Maybe as a child she was tossed up in the air and she was afraid, or she may have fallen down a big stairway and remembers that.
>
> There could have been an injury from a fall. She might have fell off a tree or something and now is afraid of heights.
>
> Maybe her mother locked her in a dark room or closet to punish her.

For a final sixth, the elevator experiences of others, as reported by gossip or the mass media, were sufficient to determine "Mary's" feelings on that score. Occasionally, too, people mentioned the possibility that the fear had been directly inculcated. For instance:

> She might have seen an elevator fall at one time or heard of one falling at some time.
>
> She might have heard about someone getting hurt on an elevator or she may have read about the elevator in the Empire State building falling.
>
> Her mother may have warned her to stay away from elevators, because of all the stories about accidents in them.

As with the betrayals and injustice that had conditioned "Frank Jones," "Mary White's" experiences with open doors, lit stoves and elevators were almost always presented as a single, unique experience, and, as frequently as not, as an event of her immediate past. There were just about as many references to her adult life as to her childhood in causal explanations, taken as a whole (Table 25), and the same held true of conditioning explanations, separately.

These causal explanations, which depended so much on conditioning, have some larger implications for popular use of abstraction and symbolism. At the one extreme, were the completely non-symbolic, concrete,

direct and immediate connections among events which characterized the thinking of people who called upon experiences involving riding elevators, turning off gas and closing doors as essential ingredients in explaining the appearance of these elements in behavior. As the next step away from this kind of concreteness may be placed the still direct and non-symbolic but abstract reasoning which related "Mary's" symptoms to experiences with an immediate content of a generically similar sort --the tracing of the elevator symptom to experiences with heights, falling or closed spaces and of the gas and door checking to thefts, fires and accidents. So far as "Mary White" was concerned, 71 per cent of those who explained her behavior made use of direct, concrete modes of explanation, and 56 per cent relied on them entirely; 84 per cent used the direct approach in either its concrete or abstract forms, and 79 per cent employed no other modes of explanation. With almost no exception, the remaining 21 per cent turned to less direct but non-symbolic ways of accounting for behavior; that is, essentially, some interpretation broader than either the concrete or the abstract direct approaches, but still relatively immediately related to the manifest content of the symptoms, was made and the causes were then related to this still more general category. In these explanations, the fact that her symptoms specifically referred only to doors, stoves and elevators was either ignored or treated as accidental and irrelevant.[33]

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[33]Of necessity, answers in which the causal nexus was stated somewhat vaguely, are included here. Since examples of this kind of causal reasoning have not heretofor been presented for "Mary White," a few examples of the type of answers called indirect, non-symbolic reasoning may help to clarify its nature:

> She's kind of nervous or something like that. (C) Maybe she's got some kind of illness.

> She's scared and forgetful. That's caused by nerves or

weakness of the body.

Everyone lives so fast nowadays that they get forgetful and don't trust their memory.

Maybe she reads sad books and thinks sad things and is scared.

She is just afraid of some of the things in life. (C) Her parents were the doting kind and protected her too much.

Since these results suggest a remarkably low public awareness of the role of indirect, symbolic expression in human behavior, a careful check was made on this point. There were, in the entire sample, exactly seven people--one fifth of one per cent--who said or even implied that the key elements in "Mary White's" symptoms might be symbolic representations of problems which had little or no superficial resemblance to doors, gas stoves, or elevators and their usual social meanings. Each of these instances is quoted here in full to illustrate symbolic reasoning about "Mary White" and to indicate that considerable latitude of interpretation was necessary to obtain even seven such instances, a simple statement that the apparent content of the symptoms might not enter directly into their etiology being taken as sufficient:

Maybe she's seen a fire where someone got burned, so she's afraid. She may have been in an accident in an elevator, some time, *but I don't know, my wife is afraid to cross a bridge, and she's never been in any accident on a bridge.*[34]

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[34]Italics indicate the portion of the answer which was taken as indicating awareness of symbolism, when an answer contains more than one mode of thought.

There's an inner fear of some kind. (C) Sometimes if they've had something happen to make them over-cautious; it's an inward fear of some kind. (C) I suppose anything that caused fear. It just comes out in those things instead of something else, though I'm not sure why.

There's some reason for her doing that. She should go to a psychiatrist and find out just what is her reason for those funny habits; they always say there's a reason for everything. (C) I don't know, there's some reason why, but it might not be concerned with the gas stove in any way. (C) I don't know, almost anything could have happened. Maybe something happened in her childhood that gave her fear of those things, but don't ask me what.

I really don't know. (P) They say it's something in her childhood that has no connection with elevators. As far as going back, she's afraid to be the cause of anyone's unhappiness. (C) I mean, for instance, if she left the gas open, it would cause an explosion; or, if she left the door open, they might be robbed. She has a conscience. (C) As far as the other thing is concerned, I don't know about it. As I say, all I've heard is that it goes back to childhood; I know nothing more about it than that.

Well, she has a good load of compulsions. (C) Suppressed hostility. (C) In compulsions, you feel hostility toward someone you are supposed to love, and you have a conflict about it. (C) You have to let it out some way, and this is socially acceptable.

Subconsciously, she wants to destroy herself even though consciously she appears content. This type of obsession could lead to serious depressive states. This type could impulsively commit suicide. (C) There is a definite inner fear complex. (C) I believe her apparent happiness and popularity is on the surface; then again, things may have run too smoothly for this person, so she may be bored, and this bored attitude may lead to a desire for sudden excitement of which she may be partially consciously aware of and partially sub-consciously. (C) She's had smooth sailing and desires a sudden change which may be an exciting episode. This type of person, having smooth sailing, becomes bored, and there might be a craving for a change.

(S) She'll never get to the top floor, that way. She's a compulsive neurotic. (C) Feelings of insecurity. (C) She feels she is not capable of doing things correctly and always must verify the things she does. She must check things constantly and keep assuring herself. (C) Repeated incidents of mental trauma, as when her mother thinks she should be beautiful where she is a homely girl. She has a subconscious desire to kill her mother and always checks the gas, afraid she may leave it on. Her conscious will not admit this and makes her check the gas. (P) Elevators are a symbol in her unconscious of something pertaining to sex, and she is afraid of elevators, not because of the elevators, but because of what they represent in her unconscious.

The significance of this aspect of the logic of causal explanations of human behavior lies, in part at least, in its influence on conclusions about that behavior. It has been indicated, with some of the other examples, that the use of equivalent conditioning as an explanation of behavior tended to lead toward a conclusion that the behavior under discussion was not mental illness. The same observation can be made for "Mary White," where, among people who offered any kind of classifiable causal explanation, conditioning was used by 75 per cent of those who said she was mentally-ill, 82 per cent of those who said something else was wrong, and 89 per cent of those who said nothing was wrong with her. The category of causal relations that has been referred to as equivalent conditioning, however, is actually a rougher sort of approximation to the underlying logic of the reasoning, which was classified only for "Mary White." That is to say, except for an explanation in terms of innate personality traits, all explanations which used direct concrete or direct abstract logic fall within conditioning, and, with only minor exceptions, all other modes of explanation fall outside of it.[35] And,

[35] A person who said she was afraid of elevators and the fear of elevators was inherited was classified as using direct, concrete reasoning, but not conditioning. Similarly, a person who said the elevator represented a fear of falling which was inherited was classified as using direct, abstract reasoning, but not conditioning. In a few instances where the behavior was traced to a more general trait like insecurity or anxiety, which was in turn traced to the direct teaching or example of others, these were classified as using general, non-symbolic reasoning and conditioning. The relationship is sufficiently close, however, that 96 per cent of the references to conditioning were classed as direct, concrete or abstract reasoning, and only six per cent of the references to causes other than conditioning were so classed.

if the underlying logic is examined more closely, it is apparent that the more concrete the logic applied, the less likely people were to say

"Mary" was mentally-ill. That is, among those whose accounts of "Mary" could be causally classified, direct, concrete reasoning was employed, at least in part, by 49 per cent of those who called her mentally-ill, 66 per cent of those saying something else was wrong, and 73 per cent of those who found her non-problematical. This difference is already more marked than the difference in the extent to which conditioning explanations were used, and the use of direct, concrete explanations as the sole mode of approach was more sharply differentiating, the proportions using the most concrete approach, exclusively, being 29, 48 and 60, respectively. Significantly enough, even if the comparisons are restricted to people who gave conditioning explanations, people who said nothing was wrong with her did not simply use conditioning by way of explanation more frequently than other groups; they also tended, when they did employ it, to use it in its most concrete form. Among those whose causal explanations were classed as conditioning, the proportions who relied entirely on the direct, concrete mode of explanation were 38 per cent of those saying mental illness; 59 per cent of the "something else" group; and 68 per cent of the "nothing wrong" majority.

While the mode of explanation was, thus, like the differences in psychological interpretations touched on earlier, significantly related to the total judgment about "Mary White" with respect to mental illness, it did not, just as differences in description did not, account for most of the tendency to see nothing wrong with her. That is, while people who used only direct concrete modes of thought were less likely to conclude she was mentally-ill, no line of reasoning about etiology led any very large proportion of those who used it to this conclusion, the frequencies running from four per cent of those whose only logic was direct

and concrete to 10 per cent of those whose logic did not go beyond the direct, but abstract, to 12 per cent of those whose modes of thought included less direct approaches. Even when the influence of both psychological interpretations and causal explanations of them are considered separately, the same general situation holds true, although the differences widen. That is, if the people who described her as careful and afraid of elevators and either attributed these tendencies to the most direct, concrete conditioning experiences or made no references to causes at all are taken as one extreme and the people who described her as anxious or insecure and attributed her personality to causes other than or in addition to equivalent conditioning as the other, then, in the first group, only one per cent regarded her as mentally-ill, and 89 per cent said there was nothing wrong with her; while, in the latter group, 21 per cent saw mental illness, and 47 per cent said there was nothing wrong. Although seven cases hardly form the basis for reliable statistical generalization, it is interesting that, in contrast to either of the preceding groups, among this small group who appeared to acknowledge the possibility of symbolic connections in human behavior four of the seven said she was mentally-ill and only one said there was nothing problematical about her.

The question of why so few people saw "Mary White" as mentally-ill or even problematical, regardless of whatever else they said about her, can be taken one step further by means of the reasons people, themselves, advanced for their classifications. Here, unfortunately, 51 per cent did not give meaningful accounts of the reasoning which led them to conclude that "Mary" was not mentally-ill (Table 28). Among the half that did, however, two ideas dominated. Close to half of those giving reasons

for saying she was not mentally-ill regarded her behavior as commonplace--so frequent, widespread and familiar among people that it could not be considered problematic. For example:

> We all have our little faults, so I don't think she has a mental illness.
>
> I don't like to ride on elevators, and I know lots of people who don't.
>
> I just don't see anything wrong with her. Lots of people act like that.
>
> I do the same, and I'm not nuts. She sounds like everyone else.
>
> There's nothing wrong with being scared of an elevator. Lots of people are scared of planes, too, but that don't mean anything's wrong with them.

Second, 29 per cent of those who explained approved of her behavior, saw it as sensible or desirable, in the light of their interpretations of its significance, and could not call such reasonable behavior mental illness. Typical of this point of view were these comments:

> She's just being very careful, and I think that's the way she ought to be, and that's O. K.
>
> It's only common sense. When a person goes away, she should go and see if the gas stove is closed and the door is closed. That's not crazyness.
>
> It's just good sense to say away from something you dislike so much, as I see it.

Aside from these two interrelated ideas, thinking about "Mary" scattered widely over a variety of lines of thought, with less than 10 per cent of those giving reasons mentioning any one of them. The most frequent of these less frequently used considerations were that her symptoms did not interfere with adequate functioning, that she could control her symptoms, herself, if she wanted to, and that her behavior did not depart sufficiently from some implicit norm to justify calling it

mental illness. Illustratively:

> If she were mentally sick, she wouldn't have a good job, and neither could she be busy and active.
>
> It's nothing she couldn't cure herself. She will just have to get hold of herself. She should take a ride in an elevator every time she gets a chance and get over her fear.
>
> She's too normal a person to be mentally unbalanced.

The small minority who perceived mental illness, on the other hand, relied primarily on, first, their conviction that her emotional responses --primarily, her fears--were deviant and, therefore, mental illness, by definition; second that her forgetfulness constituted intellectual impairment, which was, for them, the key element in mental illness; and, third, that there were no "real" causes of her symptoms which were, rather, "all in her mind." (Table 27.) Here is what they said:

> Disordered emotional response: Her being so frightened about things.
>
> That's a phobia, a psychosis. Even if she is behaving normally, this fear is creeping up inside of her.
>
> It's not normal to have these fears. Children aren't born with them; it's an acquired fear, coming from a mind not too healthy.
>
> Intellectual impairment: Her mind is awandering. She has no steady mind.
>
> She's losing her memory.
>
> Lack of cause: There's nothing there to cause this, except a mental illness. (C) There's no reason to be so afraid of an elevator; it's something in her mind.

This mental illness, even when perceived, was seldom taken seriously, primarily because she was able to function well enough, because she could overcome it herself, because she was no threat to anyone else, because it could be easily cured, or because there was no need to try to cure it. The one per cent of the entire population who regarded her as

seriously mentally-ill were thinking primarily in general terms that it might, in the long run, become more serious, or, specifically, lead to greater impairments of her functioning, and that treatment was, therefore, necessary. (Tables 29 and 30.)

This attitude that all was well with "Mary White" is most clearly seen in the fact that 80 per cent of the entire population made it clear that they did not see any need for ameliorative action in her case. (Tables 31 and 32.) And, even 15 per cent of those who called her mentally-ill, simultaneously took the position that nothing needed to be done about it. Among those who saw mental illness and explicitly recommended action, over a third were referring to self-help, a proportion which made self-help relatively more frequently mentioned in connection with "Mary White's" mental illness than in any other instance. Self-help was, also, the most frequent suggestion of the small minority who recommended action even though they did not regard her as mentally-ill. Taken by and large, "Mary White" turned out to represent normal humanity for a majority of the American public.

"Mary White's" story completes the detailed presentation of the major outlines of popular approaches to six hypothetical persons and their problems. Throughout this chapter, the attempt has been to present popular accounts without interpretation and evaluation so that the material might be available, without bias, for anyone to arrive at his own conclusions about the crucial elements in popular logic and their significance. In the next chapter, we shall attempt to evaluate the material which has just been presented, to draw on it as evidence leading to tentative generalizations about the major dimensions of the interpretive schemes popularly applied to human behavior, and how these affect thinking

about that class of human behavior called mental illness. It is hoped that the presentation thus far has been sufficiently complete and sufficiently neutral to make available to others the data which have led to these conclusions and the degree to which they are warranted.

CHAPTER 5

POPULAR INTERPRETATIONS OF HUMAN BEHAVIOR: SOME GENERAL FEATURES

Introduction

In the preceding chapter, attention centered on the unique particulars of popular accounts of six hypothetical personalities. While these are not without their own individual interest in concretely portraying popular approaches to six clinically-identifiable psychiatric syndromes, they would have little but curiosity value, if they led no further. Fortunately, however, it is impossible to conceive of people discussing these six examples entirely in isolation from one another and, more particularly, apart from their prior experiences with, assumptions about, and orientations toward human behavior. It should, therefore, be possible to discern behind their unique, concrete, varying accounts of six rather arbitrarily chosen examples of human functioning the broad outlines, at least, of the general interpretive schemes people were applying to human behavior. It is, after all, only to the extent that these more constant, general characteristics of approach can be abstracted from the separate life stories that it is possible to refer at all to popular interpretations of human behavior rather than to particular samples of human behavior.

This chapter, then, is an attempt to make explicit and to examine critically the theories of human conduct that had popular currency, so far as these may be inferred from people's implicit applications of general principles or frames of reference to six particular examples, and to the extent that they had implications for popular thinking about mental illness. Since ideological analysis can lead in so many directions, it should be made quite clear that only this limited, directly-relevant segment is essayed here. The goal is, as stated, to abstract for examination

those general ideas about human behavior that appear to have been indirectly expressed in what people said directly about "Frank Jones," "Betty Smith," and the others, and to examine them only as they constituted general frameworks into which people's thinking about those forms of human behavior loosely grouped together as mental illness had to be accommodated.

This procedure involves a kind of piecing-together, in which people's actual, incomplete statements about each example are used to construct the kind of theoretical model of human behavior that must, logically, be postulated in order for the individual statement to follow. The premises and necessary consequences of that model can then be examined and subjected to intellectual criticism. It is important to bear in mind, however, that the model is our construct, a tool for analysis. It is not maintained that people were aware that their ideas about causality involved these premises or that they knew their logical implications. It is not even suggested that people would have themselves agreed that their ideas required these premises and implications, even if they were pointed out. It is exactly because popular thinking tended to combine ideas from a number of systems of thought, without taking over the full implications of any of them, that this logical reconstruction must be undertaken to disentangle them.

Causality in Human Behavior

As the preceding chapter has indicated, the six hypothetical persons whose behavior was examined primarily posed problems of personality, personality development and the evaluation and classification of personality to the American public. In every instance except "Frank Jones," the categories of personality--"temperament, conditioning, personality" and "bad

will, defective character"--were those to which the example was most frequently assigned and, with "Jones," they were the leading alternative to mental illness. Overall, 79 percent of the examples that were not classified as mentally-ill were regarded as examples of personality; while 12 percent were classed as exhibiting the normally-expected human response to the particular, transient circumstances; and five percent, as being physically, nervously or emotionally-ill. (Four percent of these examples were not classified in any way.) Almost everyone thought in terms of personality, at least part of the time: in the entire sample, there were only three percent who did not view at least one of the examples as an instance of personality--two percent who classed all examples as mentally-ill and one percent who used only other types of illness or universal human responses as alternatives to mental illness. In the vast majority who did employ personality as an alternative to mental illness, 41 percent used it exclusively; 33 per cent divided non-mentally-ill examples between personality and natural human responses; 14 per cent between personality and illnesses other than mental; and nine per cent among all three basic categories.

If mental illness had been used by the public solely as a classification to which certain deviant personality types were assigned, these figures would indicate the exact extent to which public discussion was centered on personality. But, since mental illness was sometimes conceptualized in this fashion and sometimes conceived of as a disease which produced psychological symptoms alien to or independent of the personality of the sick person, not everything that was said about mental illness can be regarded as referring to personality.[1] In the large, however, and

[1]Conceptions of mental illness are discussed more fully in the next section of this chapter.

with occasional allowance for the not completely homogeneous nature of the materials, it is clear that we are dealing with the explanatory schemes popularly applied to human personality. These, in turn, can be reduced to the six major types of causation into which people's interpretations were classified--organic processes originating in the brain or nervous system, diffuse organic influences, innate dispositions, external circumstances, direct conditioning and other psychodynamic relationships--or, even more generally, into the organic, the innate and the social determinants of personality, and, residually, those aspects of human action which were regarded as voluntaristic, consciously-controlled expressions of personality.[2]

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[2]The category of voluntary actions must be regarded as residual in this analysis of explanatory schemes because the procedures used both in interviewing and in the classification of interview materials minimized the role of individual preferences, intentions, decisions and the like in people's causal interpretations. Attribution of the behavior of any example to his motives, intentions, etc. was interpreted as a descriptive discussion with no reference to causes, unless the respondent made it clear that he considered these factors irreducible elements beyond which causal explanation could not go. In line with this interpretation, interviewers had been instructed, in the first place, to probe for the determinants of such psychological variables. Thus, if a respondent said, "He acts that way because he wants to," an interviewer was supposed to ask: "What makes a person want to act like that?", and the answer to this question generally furnished the causal material coded. Although the study did employ this determinist approach to causality, people's references to voluntarism in human behavior were fully preserved, either in the context of psychological description or as suggestions for self-correction or both and will be dealt with more fully later in this chapter.

It may be said, of course, that any scheme for the interpretation of human behavior must include all these factors and state the relationships among them, but the fact is that psychological systems have primarily differed either in the basic elements they have chosen to emphasize or--as in the many social psychologies--in the way in which the same element

was conceptualized.[3] The situation was much the same with popular think-

[3]See, for example, Gardner Murphy, Historical Introduction to Modern Psychology, New York: Hartcourt Brace and Company, 1949.

ing: in explaining any single instance of human behavior, most people advanced interpretations which could be subsumed within some one of the six major causal categories which had been empirically defined, without reference to any of the others. Of all the examples explained, 72 percent were explained by a single major factor, while only two percent involved more complex explanations depending upon the combined effect of two or more major factors; the rest consisted of instances where alternative but independent single lines of causation were advanced. In terms of people, only seven percent even employed an explanation which involved an interdependent causal sequence, and they generally did not consistently make use of these more complex explanations, but rather applied them to only one of the examples they discussed.

The outcome is that the classification of people's explanations into the six basic categories used in the study rather adequately reproduces their causal thinking for the individual instance, but the way people combined these categories into an interrelated system can only be inferred, since people had little occasion to discuss them more than one at a time. Yet, there is some basis for this inference, for, although people generally tended to explain an individual example by a single causal factor, the factor employed also tended to vary with the example. Except for people who limited their causal explanations to only one of the six hypothetical persons examined, the vast majority introduced more than one causal factor into their accounts, with the number employed varying directly with the number of examples explained. Thus, among

people who explained only one example, 86 percent employed only one major cause or, on the average, 1.2 causes were used in explaining the individual instance. Among people who explained two examples, however, only 18 percent employed one major cause for both of them, even though they still averaged 1.2 causes per example, and, on the average, two different causes were used in explaining two cases. For people who explained a majority of the six examples, less than one percent employed a single causal factor throughout their discussions, and the average person used three or four of the six possible causes. (See Table 33.)

As these data suggest, the tendency was to give different types of explanations for the different examples, so that the more examples a person explained, the more likely he was to introduce each of the possible causal factors. As shown in Table 34, the proportion of people using any given type of explanation increased steadily from the group who discussed only one example to the group who discussed all six. In this last group, practically everyone had explained at least one example in terms of conditioning and at least one in terms of more general external circumstances; three-quarters had used an explanation in terms of the psychodynamic relationships of childhood; three-fifths had explained some example in terms of one or another of the organic factors; and half had attributed some instance of behavior to the individual psyche, whether conceived of as itself innately determined or as the effective determinant of the action. While the exact proportion of the public who used each type of causal interpretation is partly an accidental outcome of the number and type of examples discussed and the extent to which interviewers persevered in seeking causal explanations, it is clear that these factors had approximately the same relative order of public popularity, from conditioning

down to personality, regardless of the number of examples explained.

While variation in explanations from example to example was the norm, there was a slight but statistically significant tendency for people to adopt a single line of explanation and transfer it, modified only in details, from one example to the next.[4] Since an interpretive

[4]The contrast between popular thinking and technical thinking within a consistent theoretical framework can be most sharply drawn by consideration of how a dynamically-oriented psychologist might have dealt with the six examples. It seems likely, first, that he would have seen all of the examples as instances of personality, and, second, that he would have considered psychodynamic relationships a major element in the determination of each of these personalities. These relationships might, upon occasion, have been formulated in the way that has been differentiated here as direct, equivalent conditioning, but the causal explanations would always involve either the categories of conditioning or of other psychodynamics and would always refer to experiences of childhood. If these criteria are acceptable as a definition of one possible theoretically-consistent apprcach and are operationally translated by regarding as using this apprcach anyone who employed psychodynamics and/or conditioning as part of his causal explanation of an example (even if alternative explanations were also advanced) and who did so without clearly limiting the factors in his explanation to the present, then 90 per cent of the public at one time or another made use of this theoretical approach. There were, however, only five per cent who used this same framework as part or all of their interpretation of every example they causally discussed, and, of these, a fifth had this apparent consistency of approach because they discussed only one example causally. This lack of consistent application of a theoretical interpretive system which was used upon occasion is partly due to the fact that the public did not always perceive these examples as problems of personality and could not, therefore, be expected to subsume instances of non-personality problems under a theory of personality determinants. Even for those who saw only personality problems in all the examples they discussed, however, only a sixth of those who sometimes accounted for personality by this broadly psychodynamic approach consistently applied this interpretation to all the instances of personality they explained. (Ninety-one per cent of the group used this explanation at least once; 15 per cent used it as part or all of their explanation of every example they discussed.) Again, a fifth of the seemingly consistent gave causal accounts of only one example and so had no opportunity to abandon this position. If only the people who were discussing only instances of personality and who explained at least two of them are considered, 95 per cent sometimes traced personality to these psychodynamic factors, but 13 percent referred to them in connection with every example explained. If the time definition is changed to require that the explanation clearly refer the causal factors to childhood, then only one per cent of the population and three per cent of those discussing only personality adhered consistently to this basic approach.

scheme should be a general explanation equally applicable to all instances, it is worthy of note that each causal factor alone, whether organic, social, or psychic, was used by some people as the only factor needed to account for all of the instances of human behavior that they touched on. This tendency to systematize a causal factor into an explanatory scheme can be demonstrated by the fact that people who used any causal factor to explain some one example were more likely to use the same factor in explanation of another than were people who had not, and the more frequently they had used it on previous examples the more likely they were to use it again. For instance, by the time people discussed the last example, "Bobby Grey," only 35 per cent of those who had explained no previous example in terms of psychodynamics interpreted "Bobby's" behavior in the light of such relationships, while the proportion who called on psychodynamics to explain "Bobby" was 52 percent among people who had previously offered this kind of an interpretation of at least one other example. And, within the group who had interpreted other examples in terms of psychodynamic relations, the proportions calling on this explanation to account for "Bobby" rose from 49 per cent among those who had previously used this causal factor in connection with one other example to 92 percent of the small group who had previously explained four or five of the preceding examples in this way.

The data in Table 35 indicated that this tendency to extend a previous explanation to the next example explained was operative with each of the causal factors to some extent, although they also indicate that this tendency did not, in general, override the dominant image of the particular example. That is to say, if an example was not generally seen as an instance of a particular causal factor, it was not frequently

interpreted in this way even by people who leaned toward that kind of explanation, and, if it was generally seen as an instance of a particular kind, it was usually interpreted in that fashion even by people who had not previously used that sort of interpretation. For instance, "Bobby" was seldom explained in terms of impersonal external circumstances, and, although the proportion who did introduce such causal considerations rose steadily from those who had not previously used environmental interpretations to those who had frequently used them before, even in the most extreme group only 15 per cent advanced this explanation of "Bobby's" behavior. On the other hand, a majority of the public introduced external circumstances in discussing "Bill Williams'" alcoholism, and, although the proportion who did so declined steadily from those who had frequently used this causal scheme before to those who had not previously introduced it, even in the latter group a majority found "Williams'" circumstances a relevant consideration.

Roughly speaking, the relative amount of difference previous usage made in the extent to which a given causal factor was used in connection with a particular example is an index of the extent to which the various causal factors tended to be systematized. Of the six causal factors, direct organic brain processes and psychodynamic relationships showed the greatest tendency to be applied by the people who used them as generalized explanatory schemes, while conditioning, diffuse organic processes, environmental circumstances, and personality factors followed in that order.[5]

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[5]This ranking is actually based on the difference between the actual distribution of frequencies with which a given cause was used and the distribution to be expected if the use of a given cause for one example was completely independent of its use in connection with other examples, as measured by a chi square test. For instance, taking only people who answered the first two examples, a cause could be used

twice, once or not at all, with the expected values determined by the proportions using a given cause on each of the examples separately. That is, if p_1 is the proportion using a cause on the firxt example and q_1 is the proportion not using it, both p_2 and q_2 being the equivalent proportions for the second example, then the expected proportions using a cause twice would be p_1p_2; once, $p_1q_2 + q_1p_2$; and not at all, q_1q_2. The chi square values, which measure the extent of the deviation of the actual data from the joint occurrences expected from these independent probabilities, were:

Direct organic	94.15
Psychodynamics	48.08
Conditioning	35.93
Diffuse organic	29.69
Environmental circumstances	15.97
Personality	12.98

All of these values are significant at $p < .01$, and more refined tests, considering all six examples simultaneously, confirm these simpler results as to both significance and the general ordering of these six causal factors.

While organic brain processes and psychodynamics were, thus, the most systematically-used causal schemes, there was a sharp difference between these two factors--and between the social and non-social causal factors, generally--in the inclusiveness of their applicability. While some people could and did use organic theories systematically, in explaining examples of human behavior, they were not able to explain as many examples within this systematic framework as were people who had systematically used a psychodynamic or conditioning theory. The major substantive difference in modes of thought between those explaining more and fewer examples was exactly that the former group was more likely to apply a social interpretation. The more examples a person explained, the more alternative explanations of each single instance he advanced, and these additional explanations were consistently concentrated in the categories of social causation--external circumstances, conditioning and psychodynamics. It necessarily follows that the people who explained any particular example in terms of social factors were more likely to

explain subsequent examples than were people who interpreted that example in terms of one or another of the non-social causes. As shown in detail in Table 36, people who approached the first example in terms of social causality and, particularly, conditioning and psychodynamics were able to answer a larger number of ensuing examples than were people who used other causal approaches, and this greater ability to explain later questions consistently characterized the users of conditioning and psydynamics on any particular example.

The data thus far presented have suggested three criteria for evaluating the factors which entered into popular thinking about human behavior. The first of these is the relative public acceptance of each type of causal explanation, as measured by the number of people who made use of it at one time or another. Second is the extent to which each causal factor was systematized and applied repetitively from one instance to another; and, third, the range and variety of instances to which the system was applicable. Each of the causal factors can be ranked, from high to low, on these criteria, from which it is apparent that, insofar as popular thinking about human behavior approached a conceptualized system capable of general application to all instances of behavior, it tended in the direction of the behavioral model represented by direct, equivalent conditioning:

Causal Factor	Rank in Acceptance	Systematizability	Applicability
Organic processes directly affecting brain, nervous system	5	1	4
Diffuse physical processes	6	4	5
Innate personality, will, choice	4	6	6
External environment, circumstances	2	5	3
Direct, equivalent conditioning	1	3	1
Other psychodynamic relationships	3	2	2

While the model represented by psychodynamics somewhat surpassed conditioning in the extent to which the people who employed it applied it systematically, it was a good deal less familiar as a way of thinking about human behavior, and the people who used it could not adapt it to quite as great a variety of examples. In comparison with these two modes of thought, however, the other four factors were either seldom used, used relatively unsystematically, or found applicable only to limited ranges of human behavior.

These data simply serve to confirm in a more formal way the impressions derived from popular interpretations of each of the six examples. It was apparent throughout, for example, that organic processes involving the nervous system were not generally introduced to account for personality. They were viewed, primarily, as the causes or mechanisms operating in illnesses, whether these were classed as mental, nervous or physical, and, aside from their status in the area of illness, were relevant only to such problems as explaining the mechanism of alcoholism. Of all references to organic nervous system processes in explaining behavior, two-thirds were explanations of behavior classed as illness, although only a third of the examples discussed were viewed as ill. Similarly, more general physical factors like overwork and a variety of diseases were primarily used to account for transient or chronic poor health, tension and irritability and were, therefore, also mentioned disproportionately in connection with behavior that was assigned to the illness category. Environmental stresses, too, occupied somewhat the same logical status and figured disproportionately as the causes of mental and nervous illness and as circumstances precipitating tension or escape reactions like "Brown's" insomnia, "Williams'" drinking and

"Bobby's" delinquencies. Despite the fact that a majority of all examples were classified as instances of personality, it was only when their discussions turned to conditioning and psychodynamics, on the one hand, or to matters of innate disposition and conscious volition, on the other, that people were primarily referring to personality development. (This situation has already been documented for the individual examples in Tables 23 and 24 and is summarized in Tables 37 and 38.)

Among these last three interpretive schemes which seemed to have general applicability to human personality and behavior direct, equivalent condition was clearly the American public's most characteristic and pervasive way of thinking, and its underlying logic was, if anything, even more dominant than the data presented earlier indicate.[6] This popular

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[6] It was pointed out, in connection with the story of "George Brown," that the basic characteristic of equivalent conditioning--a non-symbolic equating of symptoms and causes by virtue of identical manifest content --permeated many of the explanations of his behavior that were classified as external circumstances. The same observation could also have been made about the way many people linked personality traits to psychodynamic relationships, where, frequently, the same kind of literal equation connected them, as, for example, in this instance: "He's insecure and lacks self-confidence. (C) His parents didn't teach him self-confidence when he was young." Since direct, equivalent conditioning is the only one of the categories of social causation defined not simply by the nature of the causes but by the manner in which they are related to effects, the logic of the two other social categories is not necessarily distinct from it. Moreover, the fact that rather vague or general answers referring to social causation were uniformly classed as other than conditioning, even though further elucidation would have proved at least some of them to be instances of the conditioning approach, means that the predominance of conditioning and its underlying assumptions is understated, while the extent of external environmental and, particularly, psychodynamic approaches is exaggerated.

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acceptance of conditioning as a mode of explanation was, in a way, the more remarkable because direct conditioning, if thought of as a broad scheme generally applicable to human behavior, has a number of serious limitations.

Since the materials being used in this analysis derive from the American public's discussion of imaginary characters, it is, strictly speaking, not possible to reject any interpretation of any of them as incorrect. No matter what people said was responsible for "Frank Jones'" behavior, for instance--whether brain damage, temporary drunkenness, fatigue, economic pressure, or what not, it may well be that there are real individuals who exhibit symptoms similar to "Jones'" whose behavior does derive from each of the various possible causes people thought of. "Frank Jones," of course, does not and never did exist, so it can never be empirically determined which one of the many possibilities was operating in his case.[7] It follows, equally well, that conditioning may be the

[7] The only possible exception to this statement is the case where it can be shown that it is absolutely impossible for a given cause to produce the given symptoms in any individual. But, of the many causal interpretations advanced in the course of this study, almost none of them fit this requirement. The tendency in modern social psychology has been to reject categorically interpretations which attribute personality characteristics to innate factors, but, even here, the possibility of a constitutional element in temperamental factors like reactivity, sensitivity, etc. has never been totally rejected.

correct interpretation in some concrete instances. It may be that there have been real individuals who have become suspicious to a paranoid or near-paranoid degree because of betrayals by people they trusted; it is possible that externally-enforced social isolation has sometimes caused a schizophrenic-like withdrawal; maybe there are people who never again set foot on an elevator after one unfortunate encounter; and so on.

It is, however, not necessary to maintain that the explanation of any of the hypothetical examples in terms of conditioning--or in terms of any other developmental sequence--is categorically incorrect in order to suggest that some explanations are more likely than others. Suppose, for

example, it were possible to select a random sample of people exhibiting the same symptoms of suspiciousness and violence as "Frank Jones" and to determine, unequivocally, the causes of their behavior. The frequency of occurrence in this sample of any logically-possible causal sequence would then be the probability of that particular explanation's being found to be correct in other similar instances not included in the sample. Social psychological theories of personality development are still sufficiently controversial that complete agreement among researchers on the significant causal relationships perceived in a sample of this kind could not be obtained. Nevertheless, even when an allowance for disagreement is made, it can be expected that there would be few, if any, persons in the sample whose symptomatic behavior would be traced solely to simple, direct, concrete experiences of betrayal. The problem, then, is not so much that the American people incorrectly interpreted concrete examples of human behavior as that, out of the many possible explanations they might have used, they showed a predilection for one which was relatively unlikely, limited in its ability to explain and a source of cognate logical difficulties.

The essential logic of direct equivalent conditioning has been sketched out a number of times already, in connection with concrete instances of it. As direct equivalent conditioning has been defined and used in this research, it basically requires that causes and effects be related in a rational fashion through identity in manifest content; that is, behavior is to be interpreted as directly, literally, and concretely as possible, in terms of the most usual social meanings of its elements and is, then, seen as resulting from preceding experiences in which these same elements, with exactly the same meanings attached, have previously figured. As a mode of explaining human behavior, direct,

equivalent conditioning, does not, therefore, conform to any technical position in psychology, past or present, although it is related to the more behavioristic schools of thought. Conditioning, as used technically in psychology, is a way of accounting for the transfer of original responses to new stimuli: the dog, for example, is conditioned to salivate at the sound of a bell. In this technical sense, however, direct, equivalent conditioning might almost be called "non-conditioning," for it would require that the dog respond to food as food and to a bell as a bell. It does not account for the process by which objects--human or inanimate--become defined for the individual; it starts, rather, with the implicit assumption that objects do have intrinsic meanings known to everyone and that they are responded to by everyone in terms of their inherent content--a door is a door, and people lock it to be safe; an elevator is a mechanism for getting from one level to another, and people ride them for this purpose unless they have no need to get to the higher floor or unless they have reason to regard them as an unsafe form of transportation; a wife is an object of trust and is, therefore, trusted unless she gives cause to be distrusted. Direct, equivalent conditioning, thus, ignores or denies the possibility of private, subjective, symbolic or unconscious meanings being attached to these same objects. It is in this rejection of the subjective, with its concommitant reliance on observable behavior as conveying the total meaning of a person's activity and mechanical connection of responses to external stimuli, that direct, equivalent conditioning resembles behavioristic psychologies and, particularly, the Watsonian behavioristic psychology of the 1920's. Both in the popular version of conditioning and in behaviorism, there is an assumption that behavior can be understood completely from its external

aspects and a mechanical determinism in which people's behavior is viewed as an almost automatic, reflex response to stimuli external to them and outside their control: Betray a man and he will be forever suspicious of everyone; deprive a child of toys, and he will inevitably steal to get them; frighten a woman on an elevator and she will never ride one again.[8]

[8]The mechanical determinism of this stimulus-response schema obviously pervades as well a good deal of the popular thinking about social causation that was classified as environmental and psychodynamic, rather than as equivalent conditioning. It might just as well be said: subject a man to marital stress and he will, of course, take to drink; or fire a man from one job, and he will be constantly insecure in all subsequent employment. Direct, equivalent conditioning is, however, the only one of the three categories of social causation which is defined in terms of its underlying cause-effect logic. It can, therefore, only be said that direct, equivalent conditioning invariably involves the mechanical stimulus-response model, while the same model is present in other thinking to an undetermined extent.

The limitations of this extreme behaviorism, even without the special flavor of the direct, equivalent conditioning approach, are too well known to need further comment here.

It seems likely that the conceptual model represented by conditioning was one of the contributing factors in the general lack of distinctness in popular thought. Such logically-separable elements as the class to which a given behavior was assigned, its descriptive characteristics, its causes, treatment and prevention were seldom sharply differentiated. Instead, these categories, which, in more rigorous thinking, are conceptually-distinguished so that their interrelations may be examined and specified, tended to merge with one another in popular thinking into a kind of amorphous whole in which all of these elements are somehow identical and interchangeable. The inevitable result of this syncretistic tendency in popular thought was that popular discussion of human behavior appeared, by usual logical canons, extremely unclear, confused and contradictory.

The very fact that popular logic tended to run counter to formal logic makes it difficult to demonstrate the existence of this difference, however. In the course of classifying, quantifying, presenting and analizing the views of many people, some method of ordering and organizing them had to be established and adhered to, and all such methods follow formal logic in setting up clearly defined and distinct categories. In the preceding discussion of the examples, for instance, each was presented in terms of the general class of behavior to which people assigned it, the descriptive characteristics they attributed to it, the causes they adduced for the behavior, and the corrective measures they proposed. In other words, the data were ordered <u>as if</u> people had followed this logical scheme in their discussions. This logical structuring was imposed on people's remarks, however, so that the orderliness of the data does not necessarily reflect or imply a corresponding orderliness in people's thinking. Yet, once a logical system was imported into people's discussions, the resultant data cannot, simultaneously, be coherently organized and, at the same time, reveal the extent to which the distinctions basic to that organization were not actually inherent in popular thinking. It is, in fact, a perennial problem of this kind of research to achieve clarity in the presentation of popular logic, without at the same time eliminating its differences entirely.

There are, nevertheless, some materials in this and other researches which do serve to indicate the difference in premises between the way people thought and the way their thinking has been organized, here. In people's discussions of the six hypothetical individuals, there was, for example, a good deal of variation in the extent to which they included references to causation, as this was defined in the research. If any

references to causes, however vague, even including simple statements that they were unable to specify causes are included, variation in causal discussion ran from 72 per cent who discussed "Bill Williams" causally to 92 per cent who discussed "Betty Smith" in these terms. For easy reference, the proportion of the public who discussed each example in causal terms were:

"Frank Jones" (Paranoid) 89%
"Betty Smith" (Simple Schizophrenic) 92
"George Brown" (Anxiety Neurotic) . 79
"Bill Williams" (Alcoholic) 74
"Mary White (Compulsive-Phobic) . . 72
"Bobby Grey" (Conduct Disturbance) . 91

Since these data are presented in the order in which the stories were presented to people for discussion, it is clear that variations in tendency to employ causal categories are not attributable to the operation of a fatigue factor, in the course of which people's discussions became briefer and briefer as they moved through the six stories. Nor can such differences be explained by the interviewing techniques employed, for the questions asked about each story were aimed at securing a causal discussion, and the same questions were asked about every case. And, while lack of causal discussion was sometimes attributable to the interviewer's failure to pursue the discussion far enough, it is probable that an interviewer's tendency to probe or not probe was, for any one respondent, more or less constant through the six questions.

Yet, it does not seem reasonable to suppose that people consciously shifted the level of their discussions from one example to another, in line with some significant variable running through them. Certainly, the American public was less inclined to give causal explanations of behavior they considered non-problematical. But, within the sub-groups who considered each example's behavior as problematical or as non-problematical,

much the same kind of variation occurred, with, for example, causal discussion varying from 68 per cent of those who called "Mary White" non-problematical to 88 per cent of those who called "Bobby Grey" non-problematical. So, while the perception of a problem in behavior was related to the level of discussion of that behavior, it was not the primary determinant of variations in the level of discussion from one instance of behavior to another. (The correlation between the proportion perceiving nothing wrong with an example and the proportion omitting causal discussion of that example was .53, which, with only six observations, is not statistically significant.)

The largest factor in this apparent shifting of discussion was actually the kind of distinctions imposed on what people had said. That is, there was a large negative correlation ($r = -.80$) between the frequency with which an example was discussed in terms classified as causal and the frequency with which it was discussed in terms classified as descriptive. In general, the larger the number of people classified as having made psychologically descriptive comments about an example, the lower the number classified as having made causal interpretations of the same example. As this relationship tends to indicate, people were, largely, not distinguishing symptoms from causes as sharply as the system for classifying their remarks did. They were not, themselves, particularly aware of any shifts in their discussion from one example to another but rather, from their standpoint, discussed each example in about the same terms and to about the same extent. When outside criteria of what was descriptive and what was causally-explanatory was imposed on their discussions, however, their relatively undifferentiated discussions were separated into descriptive and explanatory categories. Consequently,

given the same amount of discussion of each example, the more of it, on the average, that was classified as descriptive, the less there was to be classified as causal, and the only conclusion can be that these categories were more basic to this classification than they were to people's thinking.

This same problem of the basic categories in popular thinking was approached more directly in another research, limited to one state, in which people were given terms derived from the field of mental health and asked to indicate whether the word was associated with mental disorders as "cause, symptom, kind of mental disorder, treatment or something else."[9] With a list of five diagnostic terms--neurosis, manic-depressive, dementia praecox, schizophrenia and psychosis, a proportion varying from 21 to 57 per cent of the adult population of the State of Washington were not sufficiently familiar with the word to decide on which of the categories to assign it to. Those who thought they did know the logical status of these terms, however, were right only three-fifths of the time. On the average, those who attempted classification assigned these terms to the category of symptoms about a fifth of the time; to causes, a tenth of the time and to treatment, a tenth of the time. The problem of unfamiliarity with terms did not loom so large with a series of seven symptoms--excessive irritability, fantasy or constant day-dreaming, excessive depression, ideas of persecution, temper tantrums, chronic anxiety and juvenile delinquency--for which only from 7 to 10 per cent were unable

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[9] Washington Public Opinion Laboratory, University of Washington, "Preliminary Tabulations on Mental Hygiene Poll, November, 1949" (mimeographed). The data cited here are adapted from Tables 8-10, 15, 16, 18 and 21, pages 14-16, 26-27, 30, and 34. We are grateful to the Laboratory for permission to quote their material.

to make a classification. But, for all except the first two, where 55 and 50 per cent, respectively, correctly classified them as symptoms, these terms were more often misclassified than identified as symptoms. Among people who attempted the judgment, these symptoms were, on the average, called symptoms about 46 per cent of the time; causes, 33 per cent of the time; kinds of illness, 18 per cent of the time; and other things, 3 per cent of the time.

This lack of clear-cut boundaries in popular thinking between such logically distinct categories as class, symptom, cause and treatment, is partly still further confirmed and partly explicated by the way the same population classified terms with causal implications. For a series of three possible organic causes of mental illness--syphilis, "change of life" and heredity--there was relatively little tendency to confuse categories. The averages for these three terms were: cause, 68 per cent; symptom, 9 per cent; kind of illness, 6 per cent; treatment, 2 per cent; other, 7 per cent; and don't know, 8 per cent. But, for the one category of non-organic causation included in the study, that of rejection, only 28 per cent classed it as a cause; while 21 per cent regarded it as a symptom; 8 per cent, as a kind of illness; 3 per cent, as a treatment; 3 per cent, as something else; and 37 per cent didn't know what it was.

There is a kind of ambiguity in this example, but emotional causes of emotional difficulties generally confronted the American public with this kind of difficulty. A neurotic symptom, for instance, might well be <u>feelings</u> of rejection, and, given the dominant mode of approaching human behavior, these feelings were likely to be viewed as the automatic product of experiences of rejection. Rejection causes rejection; the symptom is the invariant outcome of the cause; and the cause is

unequivocally indicated by the symptom. Under these circumstances, the symptom is the subjective counterpart of an exactly equivalent objective experience; it stands in one-to-one correspondence with its cause and cannot be sharply distinguished. The two, therefore, tend to merge into a compound unit--"rejection," which is both cause and symptom in the same way as a coin has two sides. With organic causes of emotional symptoms, on the other hand, there is no scheme by which identity can be established between cause and symptom; the two necessarily derive from different orders of content. A brain lesion may produce delirium, for instance, but there is no sense in which a brain lesion either <u>is</u> delirium or is not to be distinguished from it. In situations like this, popular thinking has far less difficulty both in perceiving that two elements are present and in deciding which came first.

It seems clear that these logical difficulties are inherent in the conditioning model because of its basic premise that outcomes are related to causal events by the most direct, mechanical and literal path possible. Any conceptual system which assumed that the same experience --parental rejection, for instance--could, depending on a host of other factors, lead to a variety of direct, disguised or symbolic emotional expressions all equally symptomatic of this same cause or which, conversely, assumed that the same emotional symptom might be the outcome of varying emotional experiences must necessarily distinguish more carefully between causes and symptoms than a conceptual model in which the two are identical.

Although conditioning was, irrespective of these conceptual difficulties, the dominant popular approach to casuality in human behavior, it is not so clear that a concern with causation was, itself, central in

popular orientations toward human behavior. It is striking that this research attempt to explore people's thinking about the causes of individuals' behavior produced so much material that was related, instead, to the control of individual behavior; 97 per cent of the public spoke in action-related terms at least part of the time in their discussions of the six examples, and judgments about action entered into well over half (59 per cent) of all the examples discussed. It may, perhaps, not seem remarkable that considerations of treatment and correction arose in the course of deciding whether or not each hypothetical person was mentally-ill or whether or not his mental illness, if it existed, was serious. But these subsidiary questions were not, in general, asked of people who said that there was nothing wrong with the example under consideration. Without any questioning that encouraged it, these people, who were asked only about the causes of the behavior, nevertheless introduced evaluation of the need for action into their supposedly causal discussions about as frequently as those who were asked the additional questions. Of the vast majority (86 per cent) who classified at least one of the six examples as non-problematical, 83 per cent made action judgments about one or more of the examples they regarded as non-problematical; while, of those who regarded at least one as problematical (98 per cent of the public), 89 per cent referred to the action-control dimension for one or more of their problem cases.[10] This small difference is largely

[10] "Mental illness" and "something else wrong" are combined here, since both these classifications resulted from the questions asked in addition to those referring to causation.

attributable to the fact that people more often classified examples as problematical than as non-problematical and so had a greater opportunity to refer to action in the context of problematical examples than in the

context of non-problematical ones. In terms of the examples, themselves, evaluations of the need or lack of need for action or of the type of corrective action indicated were made in connection with 58 per cent of those classified as non-problematical and 59 per cent of those classified as problematical. While there was a good deal of variation among the six examples, in three of the six people who found the behavior non-problematical made action evaluations more often than people who found it a problem. (Table 39.)

The dominance of a practical action orientation is suggested as well by the very quality of immediacy which pervaded causal explanations of human behavior. In discussing the three men whose stories were considered, the largest single group of people had no need to draw upon factors other than those operating in their current situations, and this tendency to focus on immediate circumstances in accounting for behavior was as much present when people were accounting for the development of personality as when they were explaining the etiology of mental illness. (Tables 25-26.) It was only as the examples themselves, increasingly suggested children rather than adults that childhood experiences were increasingly introduced into people's accounts. References to family life were least frequent for the men, who were described as chronologically mature, married, working, and so on; they were relatively more frequent for "Mary White," who, though young, was independent, working and about to marry. The role of childhood experiences became much more central in the case of "Betty Smith," who, though chronologically adult, was described as the dependent child of her parents, and, of course, was necessarily the exclusive focus of attention for the one example who was still a child. Even in the case of the child, "Bobby Grey," it can be

said that at least a third of the public were thinking in terms of his present experiences, and not of more remote portions of his childhood.[11]

[11] By definition, the people who classified him as responding to current circumstances, as shown in Table 16, were thinking of current happenings rather than earlier periods in his life. The same is also true of some of the people who classified him in other ways, as was the case for other examples, but the difficulty of determining reliably from what people said, at what time in his life the events they were describing had occurred led to the decision to restrict time analysis to the more easily recognizable major epochs of childhood and adulthood.

In general, then, the more removed the example was from childhood, the less frequently childhood was introduced in explanation of the behavior. It was only when childhood, itself, appeared to be part of the immediate past of the person that popular explanations found this life period to any large extent relevant in understanding the person.

Apart from the tendency to seek immediate explanations, which suggests a search for manipulable factors, the time of the determining experiences often appeared to be an accidental factor in people's remarks. That is, for each example, there was always a sizeable group for whom the question of when the experiences took place appeared to be irrelevant, in that they made no attempt to define it or offered parallel experiences at different times in life as equally determining. Beyond this apparent lack of concern with time, moreover, people shifted back and forth from example to example explaining one in terms of his recent experiences and another in terms of his early ones. In the course of discussing the five adult examples, 65 per cent of the public referred to childhood experiences in at least one instance, with 40 per cent referring only to childhood experiences for the examples in which they mentioned childhood at all and 25 per cent looking upon childhood experiences as possible alternatives to explanations of the same example

in terms of the present. On the other hand, 95 per cent had explained at least one person in terms of his present situation, with 70 per cent making no reference to other times in the lives of the persons they so explained. Four per cent never made any clear references in any of the examples to the time at which the determining factors had occurred, so it can be deduced that 31 per cent of the public restricted all of the explanations they advanced for the five adults considered to their immediate circumstances, while one per cent always traced the present behavior of those examples they explained at all to events which had occurred in childhood. The remaining 64 per cent of the American public was more eclectic in approaching time; as indicated, 25 per cent found the past and the present equally serviceable in accounting for a single example, and 39 per cent called on the past to explain some people, but accounted for others without leaving the present.

The action emphasis already suggested is much more strongly confirmed by the way in which causal explanation was related to comments about actions. It has been indicated before that, consistently for each example, the people who found the behavior non-problematical were less inclined to discuss it causally than those who saw some problem in it. For the six examples taken together, there was no reference of any kind to causation in 23 per cent of the non-problematical examples and 14 per cent of the problematical ones. Although this difference is not large, the fact that it was maintained consistently throughout the examples and the fact that it occurred in the face of interviewer efforts to probe for causes in all cases, whatever the individual respondent's own tendencies, reinforce the impression that a practical, action orientation was more basic to popular approaches to human behavior than an

interest in its causes. As this difference in the extent of causal explanation of problematical and non-problematical instances of human behavior at once suggests, behavior which was viewed as non-problematical raised no practical questions of controlling it and consequently required no explanation.

There were, however, at least two factors in the popular tendency to omit explanation of non-problematical behavior:

1. As already suggested, people who viewed an example as non-problematical were, on the average, twice as likely as those who found the behavior problematic to accept the behavior to the extent that they felt no counteraction was indicated. While these differences were negligible or non-existent in the case of the three examples who were described as exhibiting anti-social behavior, on the average, for all examples, the need for corrective action was explicitly denied in 21 per cent of the non-problematic examples and 10 per cent of the problematic ones or, when the comparison is limited to examples for which any kind of action reference was made, 36 and 18 per cent.

2. People who called an example non-problematical were also more likely to view the behavior as a voluntary act, either in the sense that the behavior was regarded as a result of the individual's conscious intentions, decisions or choices, or in the sense that the individual was presumed to be able to control or change his own behavior if he chose to. While people seldom clearly and explicitly indicated that they considered the behavior of a particular example voluntary in the first sense,[12]

[12] All told, 18 per cent of the public made some explicit reference to the role of volitional elements in the behavior of one or more of the hypothetical characters they discussed, although these references were rarely classed as an ultimate causal explanation. Except for the story of "Bill Williams," the alcoholic, whose drinking 12 per cent of the public felt was intentional, only a scattered one, two or three per cent clearly referred to the behavior of any one example as voluntary. The category of "Conscious choice, preference, willed action" is shown for each example in Table 19.

those who did so were, 51 per cent of the time, referring to examples they considered non-problematical. (In contrast, only 39 per cent of all examples were classified non-problematical). For each example, the group who said there was nothing wrong was at least twice as likely as those who said there was something wrong to attribute the behavior to the deliberate actions of the individual. This tendency was previously noted in discussing the alcoholic, "Bill Williams," who was the only instance where explicit reference to voluntary elements in behavior occurred frequently. For that example, 20 per cent of those who saw nothing wrong with his drinking said he drank because he wanted to, while only 9 per cent of those who took a more problematic view of the behavior did. (See Table 21.) And, though clearcut references to voluntarism were infrequent, a careful examination of the differences in psychological depiction between those who called an example problematic and those who did not suggests that those of the non-problematic view also tended to use more frequently descriptions which at least implied that the behavior was or should be within the individual's control: such categories as "Frank Jones'" being "mean" or "nasty," "Betty Smith's" conscious avoidance of people because she felt shy around them, "Bobby Grey's" desire to impress others or receive attention, and "Mary White's" wanting to be careful and preferring not to ride elevators--all these categories were more frequent in the descriptions of people who found the behavior non-problematic, and all of them suggested an element of individual decision. Beyond a direct or indirect ascription of voluntarism to the behavior they were discussing, people who regarded it as non-problematical clearly tended to feel that, if positive action was indicated to correct the behavior, it was of a kind that the "person" in question could undertake

for himself. Of all non-problematic examples for which corrective action was proposed, 41 per cent involved recommendations of self-help and self-control; of comparable problematic examples, 27 per cent did.

The importance of both these differences is that the disproportionate failure to refer to the causes of behavior on the part of people who found nothing wrong with it is almost entirely attributable to a lack of concern with the causes of behavior which, on the one hand, appeared to be acceptable and required no modification, or which, on the other, while not necessarily approved of, appeared to be the voluntary choice of the individual concerned and subject to his own modification. As Table 40 makes clear, it was only the people who meant by "nothing wrong" one or the other of these two formulations who frequently omitted causal explanations. Generally speaking, causal explanation was at a low for behavior which was fully acceptable--that is, classified as having nothing wrong and as needing no corrective action; it was also relatively low for behavior which was viewed as voluntary, personality controllable or disapproved of in moral terms--that is, behavior for which self-help was prescribed, irrespective of whether or not something was wrong with it;[13]

[13] It has already been pointed out, in connection with "Frank Jones," how the classification of "nothing wrong" would be used to express intense moral disapproval.

causal explanation was at its highest whenever the behavior was problematical in some other sense and, especially, whenever it required extra-individual measures to cope with it. The differences are so great, for each example and overall, as to leave no doubt of the influence on causal explanation of these action considerations of acceptability and voluntarism.

Causal explanations were offered for 59 per cent of all examples which were fully acceptable, 69 and 76 per cent, respectively, of non-problematic and problematic examples regarded as amenable to voluntary control, 85 per cent of examples regarded as unacceptable but not to the point of demanding action, and 93 and 90 per cent of the non-problematic and problematic examples which appeared to require external intervention. It can almost be said that people first evaluated the behavior to decide whether it required alteration; only if it did, were its causes relevant, and then only insofar as knowledge of them appeared relevant to the determination of appropriate means of correction.

The primacy of action considerations in popular social psychology should not be too surprising in the light of two considerations. In the first place, the conditions of human existence are such that people must deal with one another, and, in this process of interaction, they must take account of each other's actions--each must predict how others will respond to his acts, each must guide his own actions in the light of the expected responses to others. Popular thinking about human behavior originated from the demands of this complex system of interrelated acts, and its conclusions--whether in the form of folklore, proverbs, maxims or adaptations of social psychology--must ultimately serve these needs. The fact is that the constant and immediate problems of human relationships are problems of action and might quite reasonably be expected to be first perceived in those terms. In the second place, however, the fact that popular speculation about human purposes and actions did not depart far from the practical circumstances that initially gave rise to it must be considered as another manifestation of American pragmatism. While its sources and full implications are far beyond the scope of this

work, it has long been recognized by students of American culture that the characteristic American philosophy and approach to life is pragmatism, which is, in spirit and in aims, a highly practical, instrumental orientation. As Commager has pointed out:

> Theories and speculation disturbed the American, and he avoided abstruse philosophies of ... conduct as healthy men avoid medicine.... No philosophy that got much beyond common sense commanded his interest....the American was incurably utilitarian, and it was appropriate that the one philosophy which might be called original with him was that of instrumentalism.[14]

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[14] Henry Steele Commager, The American Mind. New Haven: Yale University Press, 1950, p. 8. Dr. Commager provides a far more complete analysis of popular versions of pragmatism than can be essayed here.

It is certainly consistent with the pragmatic style of thought that popular theories of human behavior concentrated primary attention on its practical consequences and the means by which it might be altered, and subordinated to these action goals any more general concern with the causes of human behavior.

This popular emphasis on action may seem, at first sight, incompatible with the kind of causal logic people did use when causal explanation became relevant. For the instrumental concern with correcting, changing or controlling behavior necessarily entailed some voluntarism; it required the assumption that people were free to act, that they could change or be changed. When behavior was causally explained, however, the typical interpretation incorporated the highly deterministic model of causation in human affairs that is represented by direct, equivalent conditioning. Once again, the difficulty is not new; the existence, side by side, in American thinking, of a morality and action system based on free will and of a scientific determinism that was in theoretical opposition to it led Commager to remark, "Americans believed in a universe

governed by laws which were immutable and unassailable but which left room, somehow, for the play of free will."[15]

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[15] Ibid, p. 28.

The conflict of voluntarism and determinism in the kind of thinking about human behavior explored by this research did not arise at the action level, however. Historically, theologians, philosophers and psychologists who have attempted to reconcile free will and determinism confronted the question of how a person could be held free to choose his acts or to change himself, if his behavior must be viewed as the wholly determined outcome of his experiences. Popular thinking was not caught in this dilemma, because, as has been indicated, behavior that was viewed as a matter of choice, subject to the individual's own volition and control, was simply exempted from the determinist causal scheme. In popular logic, behavior was determined if "something made a man act that way," and this "something" most usually was amenable to modification by others, if not by the individual himself. If, on the other hand, behavior was voluntary, then "nothing made him do it," and no further causal explanation was possible, but, by the same token, the individual could change himself. As this oversimplification implies, the average person thought in terms of concrete instances rather than abstract principles and, in the concrete instance, the divergent principles of free will and determinism were not simultaneously applied.[16]

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[16] This action dilemma is not the only difficulty inherent in the simultaneous adherance to a belief in free will and a belief in determinism. As the next section of this chapter will indicate, popular thinking did find the two difficult to resolve when it came to assessing behavior and assigning moral responsibility for it.

Far from being in open contradiction to the requirements of an action system, the particular form of determinism popularly espoused was peculiarly adapted to them. The important characteristic was that behavior, though externally determined, was generally not so completely determined as to be irreversible or, even, difficult to reverse. If the approach of direct, equivalent conditioning often appeared to attribute basic personality trends to relatively trivial experiences, the ease with which human personality was determined by one immediately-prior experience was matched only by the ease with which the effects of that conditioning experience could be undone by another equivalent experience: if one person's actions had made "Frank Jones" suspicious of everyone, another's could restore his faith in humanity; if "Betty Smith's" or "Bobby Grey's" behavior represented unwise parental methods, a change in these methods could immediately restore "Betty" to sociability or "Bobby" to non-delinquency; if one unfortunate experience with an elevator created a phobia on "Mary White's" part, another more benign experience could demonstrate that elevators were not so fearful. The very emphasis on immediate events in causation and the postulation of easily-perceivable rational connections between these events and the resultant behavior suggests the extent to which causal explanation was intended to single out the levers through which rational control over the behavior could be exerted.

The fact is that, in its entire style of thought, direct, equivalent conditioning is an almost perfect expression of the pragmatic outlook, and is supported and confirmed by it. Like the pragmatic approach generally, direct equivalent conditioning is highly empirical and essentially atheoretical. That is, it selects as all of reality only the most overt, manifest, externally-perceivable aspects of human

experience and behavior and deals with them literally and concretely in terms of their "objective," "obvious" or "self-evident" meanings. In so doing, direct, equivalent conditioning entails a belief that things are, in fact, always what they seem to the external observer or, in other words, that common sense is a sufficient guide to understanding of human behavior. Direct, equivalent conditioning is, in short, the common sense explanation of human behavior, the interpretation which appeared most plausible, reasonable and understandable to people in the light of their own everyday experience. Its appeal and its authority alike derive from the unbounded pragmatic faith in common sense. As William James, one of the leading exponents of American pragmatism put it, "It is only the minds debauched of learning, who have ever suspected common sense of not being absolutely true."

That common sense should continually find confirmation in everyday experience of the simple causal relationships postulated by direct, equivalent conditioning is itself a function of the pragmatic emphasis on action. In the form in which pragmatism was popularized, at least, success in application is the only test of the truth of an idea, so success in controlling behavior is sufficient evidence that the theories are correct. Nevertheless, the kind of prediction and control of the actions of others that is involved in everyday human relationships actually can and does proceed successfully, irrespective of the nature of its theoretical underpinnings. That is to say, anyone may successfully predict how a given person will react under certain circumstances and arrange the circumstances to produce the consequences he desires, simply by having observed that an empirical connection exists or by knowing how the person usually reacts, without having any idea of why the connection exists

or how the person developed his usual reactions. The knowledge of the facts of the person's character, the facts of the situation, and past empirical relations between the two suffices. Despite their essential irrelevance to this practical action situation, however, the pragmatic test of truth appears to validate any theory of the causes of human behavior which happens to accompany this success in action. To take a homely instance, a man who wishes to please a woman may observe that women generally like to receive flowers; he brings this woman flowers and she is, in fact, upon this occasion, at least, pleased (although it is always possible that he will be bewildered to discover that she is indifferent to his flowers, which were exactly identical with the flowers received with pleasure from some rival). By pragmatic standards, since he has succeeded, he understands women or this woman, at any rate. So far as action decisions are concerned, it makes no difference whether he has no rationalization of his methods, or attributes his success to woman's vanity, to an instinctive love of flowers in the female, to her earlier experiences with flowers or what not. His causal theory, if he has one, is quite irrelevant to his actions and is in no way tested by them, but is, nevertheless, automatically confirmed by them.

Direct, equivalent conditioning sounds so reasonable, corresponds so literally to immediate sense perceptions, avoids abstruse, imaginative flights into the realm of the unknown, intangible and irrational, and is as much confirmed in daily action as any other causal theory. In all these qualities, it epitomizes the values of practicality and is, therefore, a comfortable answer to people's need to feel that they do, in fact, understand themselves and others. It is, at the same time, an image of human behavior which is most antithetical to that advanced by modern

psychiatry and psychology. The less mechanical, less rationalistic interpretations of dynamic psychology--simply, for example, the suggestion that "people are not always what they seem" or that people have qualities and motivations not always accessible even to themselves or that human motivations are not always self-evident and not always rationally derived--flatly contradict the basic assumptions of popular thinking about human behavior and are easily dismissed as far-fetched, ridiculous, contrary to common sense, experience, and the self-evident truths about human behavior the public already knows. As this divergence suggests, by its very emphasis on reasonableness--rationality and control, the popular interpretive scheme represented by direct, equivalent conditioning was singularly ill-adapted to the explanation of unreasonable or uncontrolled behavior--that is, mental illness. With the main features of this general interpretive scheme before us, its influence on popular conceptions of mental illness may now be more directly approached.

The Logic of Mental Illness

This venture into the general interpretive schemes popularly applied to human behavior began, it may be recalled (Chapter 4, pp. 9-10), from the conclusion that the symptoms or syndromes that people associated with mental illness did not sufficiently define their conceptions of it, since the same symptoms, when presented to people in concrete examples, were frequently not perceived as mental illness. It was, therefore, suggested that there must be other criteria, inherent in the way people classified and interpreted human behavior, which determined the conditions under which people perceived as mental illness behavior which otherwise fitted its descriptive characteristics. The preceding, lengthy examination of

popular interpretations of human behavior was undertaken in the expectation that from it would emerge a more definitive view of popular conceptions of mental illness, and it is to these that we now return.

The review of popular approaches to the lives and problems of six hypothetical individuals has made it clear by now that popular difficulties with the concept of mental illness were, largely, not semantic ones, but were, rather, logical and psychological. A few people did refer to emotional illness as a category distinct from mental illness, and a few defined as psychiatric problems individuals whom they did not regard as mentally-ill. In both these instances, it does appear that the distinctions being made were largely verbal and did not imply a view of the behavior or of its correction which differed substantially from a technical view of mental illness. These people, who can be regarded as recognizing mental illness but using different terms to refer to it, were, however, only one or two per cent of those who did not see mental illness for a particular example. (Tables 16 and 31.) For the rest, people who referred to a given instance in terms other than those of mental illness were distinguishing the behavior as different in implications as well as in name.

The major clues to the factors other than the intrinsic character of the behavior that were popularly needed to determine the presence or absence of mental illness come from the considerations people introduced when they explained why one instance or another did or did not fit their conceptions of mental illness. As the many illustrations which have already been cited exemplify, these explanations of why a particular example was or was not an instance of mental illness were usually, implicitly or explicitly, general assertions about the nature of mental illness rather

than arguments ad hominem, and discussion of "nervous breakdowns" necessarily proceeded in generalized terms. Because of its generic quality, it is possible to infer from the composite of everything people said in support of their classifications of the hypothetical persons and of "nervous breakdowns" something of the non-symptomatic factors underlying popular conceptions of mental illness. The material which follows is, in fact, simply a summary and interpretation of the data which have been presented in concrete detail for each of the examples and in Tables 27-28.

In deciding whether any one instance of behavior represented mental illness, people generally relied on only one of three possible criteria: either its intrinsic character, or its causes, or the treatment needed to correct it was used as the determining consideration. In their discussions of each of the six examples and of "nervous breakdowns," an average of 87 per cent of those whose criteria were explicit enough to be classified referred to one criterion, with a range of from 75 per cent of the discussions of "Bobby Grey" to 97 per cent of the discussions of "Mary White." Except for "nervous breakdowns," which were an abstract category rather than a concrete instance of behavior, the major consideration in each case was the intrinsic character of the behavior, although emphasis on it varied from almost exclusive attention to the character of "Mary White's" behavior to only a plurality who focussed on the quality of "Bobby Grey's" behavior. The nature of the causes of the behavior received secondary attention (except in the case of "nervous breakdowns," where it was the primary consideration), while treatment needs were always the least frequently consulted criterion. (See Table 41.)

When the criteria people used in any one of the seven situations in which they were asked to explain why a particular syndrome was or was not

mental illness are combined, however, it becomes apparent that almost no one depended on any single criterion throughout the entire discussion. Essentially everyone (98 per cent) took account of the intrinsic character of the behavior, but this was the sole and sufficient criterion for only eight per cent. Instead, for the largest single group, (44 per cent), it required a combination of character, causes and treatment to decide all seven instances, and for 38 per cent the criterion was the nature of the behavior in combination with its causes. Thus, for over four-fifths of the American public, mental illness tended to emerge as behavior of a certain kind that was attributable to certain causes or not attributable to others; and over two-fifths carried the definition one step further to add--and not amenable to certain forms of correction.

To the extent that definitions of mental illness in terms of its intrinsic qualities entered into the logic by which people decided how to classify the individual examples, these explicit statements of the crucial characteristics of mental illness tended to confirm those suggested by the purely descriptive discussions that had preceded. That is to say, two major sets of descriptive criteria were used, the one centering around the kinds of symptoms which had dominated popular descriptions of psychoses, the other stressing the popularly perceived qualities of non-psychotic mental illness. In the first position were 28 per cent of the public whose descriptive definitions of mental illness were based entirely on cognition and rational control: these were people who decided whether or not individual examples were mentally-ill on the basis of the presence or absence of intellectual impairments, violence, criminality, or of rational control, generally. A second group, comprising 30 per cent of the public, sometimes defined mental illness by

these more cognitive criteria, but added to them broader criteria of emotional or functional deviancy: for this group, as for 17 per cent who relied only on the latter criteria, mental illness was defined as a distorted perspective on reality, a deviant emotional response to reality or an impaired ability to cope with reality. A final 25 per cent thought of mental illness, descriptively, as deviancy, but did not indicate the direction or quality of the abnormality.

It is apparent that these formulations of the nature of mental illness correspond not only with initial descriptions, but are also roughly equivalent to the two major descriptive ways used to distinguish psychotic from non-psychotic mental illness. Given these similarities, it is not surprising that the three are interrelated. As indicated earlier, it was the small group who defined non-psychotic mental illnesses as a lesser degree of emotional or functional deviancy than psychoses who were most likely to adhere to a general conception of mental illness which consistently included non-psychotic forms of mental illness. And, recognition of the specific examples as instances of mental illness was, in turn, related to this general usage. Put more generally, people whose usage consistently included non-psychotic mental illnesses were most likely to think of the different syndromes as varying degrees of emotional-functional impairment and to use this criterion of deviancy in discussing specific examples:

General Usage of Mental Illness	Proportion Defining Mental Illness as Emotional or Functional Deviancy
Consistent non-psychotic inclusion	59
Inconsistent non-psychotic inclusion	45
Inconsistent limitation to psychotic	42
Consistent limitation to psychotic	29
No impression	19

And, it was only this approach to mental illness in terms of emotional deviancy that conduced to perceiving mental illness in concrete instances, especially when the examples did not exemplify violent, anti-social behavior. As shown in Table 42, people who defined mental illness in terms of a defect of intellect, or, of general deviancy, were much less likely to classify each of the examples as mentally-ill, and it made relatively little difference whether or not their general discussions of mental illness, preceding the concrete examples, had been consistently in line with the inclusion of non-psychotic syndromes. It was only in the group whose usage derived from emotional deviancy that a sizeable proportion consistently recognized more than violent psychosis as mental illness: 46 per cent of them recognized at least the non-violent schizophrenic reactions of "Betty Smith," while 20 per cent extended their recognition of mental illness at least through the neurotic pattern of "George Brown." These proportions rose to 52 and 25 per cent, respectively, in the subgroup whose definition of mental illness as emotional deviancy was combined with a consistently non-psychotic general use of the term and fell to 41 and 16 per cent in the subgroup whose usage was not consistently non-psychotic. In contrast, however, even where previous usage had been consistently non-psychotic, only 22 per cent of those who conceived of mental illness in terms of violence and intellectual defect and 18 per cent of those who had some undefined concept of deviancy consistently recognized non-violent psychotic reactions, while only 10 and five per cent, respectively, extended recognition as far as neurotic trends. In other words, where either defects of cognition and control or an undifferentiated notion of deviancy were used to define mental illness, it was generally only the violent paranoid of the six examples--

and, frequently, not even he--whose behavior was sufficiently uncomprehending and uncontrolled to qualify as mental illness, in practice, irrespective of the nature of the abstract discussion that preceded. Identification of mental illness with deviancy of emotional response, however, led to a conception which almost invariably included the violent psychotic and, over half the time, extended through the quiet, withdrawn psychotic reactions typified by "Betty Smith." The one position identified mental illness, with the stereotype of the "lunatic"; the other, with psychosis more broadly conceived; but none of the major usages resulted in as broad an application of the term mental illness to concrete instances as was suggested by general discussions of the term.

These results, in fact, serve to extend and confirm the scheme presented in Chapter 3, p. 41. It was suggested there that the meaning of the term mental illness almost always tended, in popular usage, to revert to psychosis, and that the distinction between psychotic and non-psychotic in popular usage actually more closely approximated a distinction between severe or violent psychoses, on the one hand, and less severe or, at least, non-violent psychoses, on the other. Just as the criteria for distinguishing psychotic from non-psychotic syndromes appeared there to be the logical element which resulted in this restriction of the popular content of these terms as compared with their technical definitions, so it was the addition of non-descriptive criteria that produced the rather restricted range of behaviors perceived as mental illness, even when it was defined as emotional deviancy.

There were, in essence, four major ways of looking at mental illness, apart from the nature of the behavior, which was a necessary requirement to all of them. It may be said that behavior which, on the surface,

appeared symptomatic of mental illness was classified as mental illness only when it met the additional conditions inherent in these different views of mental illness. At the same time, each way of looking at mental illness tended to delimit and define the kinds of behaviors that could, consistently with that conception, be considered mental illness. Each of these ways of defining mental illness, therefore, leads to a somewhat different image of it, though one which is, or can be, internally consistent, once its premises are granted. The premises, themselves, are an application of principles derived from general conceptual schemes for the interpretation of human behavior and illustrate the influence of broader orientations to human behavior on popular thinking about mental illness. For the sake of clarity, these major conceptions of mental illness will be sketched in ideal form, though no single member of the public ever elaborated any of them in quite so rationalized a way.

1. It is possible to define mental illness in the terms of an extreme physiological behaviorism, in which "mind" and "consciousness" are regarded as inexact, poetic references to the functioning of the brain and central nervous system. This is a kind of "physiological monism" which distinguishes mental illness from other illnesses simply on the basis of the organs or physiological processes affected. In this view, mental illness is, in short, an organic disease of the brain or central nervous system. It differs from, say, heart disease or diabetes in the physical locus of the illness and, because of the organ affected, results in different symptomatic manifestations than they do. Its symptoms, characteristically, are what may be expected from a brain impairment: primarily cognitive impairment and attendant loss of control, violence and legal incompetence. This way of defining mental illness

can, of course, logically be extended to translate personality and emotional manifestations into physiological processes, but, in practice, the emphasis on the brain as the source of mental illness leads in turn to an emphasis on strictly mental or intellectual functions and, correspondingly, to a limitation of mental illness, in practice, to the psychoses and to other acute manifestations, as, for example, the emphasis on physical damage to the nerves in "nervous breakdowns" permits their inclusion.

For people who adhered to the "direct, equivalent conditioning" theory of personality determination, this definition of mental illness had the obvious advantage of removing mental illness from the social psychological sphere. Since mental illness was, essentially, an illness like any other, it was, by analogy with other diseases, a condition pathological for the individual affected and different from his normal state.[17]

[17] It may be said that physical illnesses are more accurately defined as conditions pathological for the species rather than the individual member of the species, since this definition would include chronic illnesses like glandular or metabolic disturbances or congenital defects that are, in fact, the usual condition of the individual. With most physical illnesses, however, and especially with the contagious and acute illnesses which people generally think of first, the two definitions are identical since whatever is not usual for the species is not usual for the individual species member either. The broader definition of illness finds its counterpart in thinking about mental illness in the view which finds it impossible to define as mental illness any behavior which is frequent, common or widespread among the members of a particular culture. It may be added that it was not necessary to define mental illness as an organic illness in order to draw either of these analogies with physical illness.

It was caused by a congenital anomaly, an infection, an organic injury, and the like or by environmental stresses which precipitated organic damage. Except in the first instance, its onset was, therefore, marked by symptoms which represented a relatively acute shift from the individual's usual behavior or state of being. These symptoms were organically determined, independent of and unrelated to his pre-illness personality,

and were, consequently, in no way connected with the kinds of directly related experiences that accounted for non-problematical personality and behavioral tendencies. In effect, then, the leading popular theory of personality determination which stressed the reasonableness, inevitability, and predictability of human responses to the forces which shaped personality, was never put to the test of accounting for aberrant personalities. As long as this organic conception was adhered to consistently, individuals whose behavior was not a direct reflection of prior experience or whose responses appeared unreasonable and unpredictable in the light of the simple cause-and-effect model of direct, equivalent conditioning were not personality problems that the scheme failed to explain adequately, but could be accounted for in terms of organic brain disease. This logical solution to the problem of mental illness placed it outside the personality frame of reference and so eliminated the need to decide in what sense emotional tendencies which were the reasonable product of the experiences which conditioned them could also be regarded as mental illness, but at the same time it tended to require an approach to personality which minimized the pathological character of certain emotional patterns.

At any rate, this conception of mental illness as organic brain disease was clearly the image that showed through the discussions of 20 per cent of the public, at least part of the time. Whenever people defined mental illness as an organic malfunctioning of the nervous system, or reasoned that the brain, being part of the nervous system, would be affected by its malfunctioning, or concluded that a given instance was or was not mental illness on the basis of the presence or absence of brain damage or of the possibilities of organic brain injury resulting

from an agent like alcohol, the only implication that could be drawn was this organic conception of mental illness. In addition to the fifth of the public who made clear their organic premises in these ways, there were another 15 per cent whose views of mental illness appeared to tend in this direction even though they never verbalized the logic just outlined. That is, their causal explanations of the hypothetical persons they considered mentally-ill made use only of organic processes or of the kinds of environmental stresses believed to precipitate organic breakdowns of functioning, while their explanations of non-mentally-ill examples relied primarily on conditioning and psychodynamics.

2. It is also possible to define mental illness in terms of the premises of mind-body dualism, an approach which is historically older than the preceding view. That is, a tendency to dichotemize reality into "the physical" and "the mental" can result in the definition of mental illness as <u>any illness or instance of pathological behavior which cannot be attributed to "the physical."</u> This conception of mental illness as non-physical was used, at least part of the time, by 32 per cent of the American public, who argued, on the one hand, that behavior was not mental illness because its causes or manifestations were physical or, on the other, that it was mental illness because no physical causes could be discerned or, more positively, because its causes belonged to the class of the mental--worry, mental strain, emotional conflict, and so on.[18]

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[18] Many more than 32 per cent used one or another of these arguments in the course of their discussions, but wherever people used these considerations in combination with those which made it clear that the basic distinction was reality vs. unreality rather than physical vs. mental, they are classified in the next usage group rather than here.

So far as differential symptomatology is concerned, the effect of this usage is to attribute physical or psychosomatic symptoms to physical causes, and physical causes to physical rather than mental illness. The result is that syndromes which feature fatigue, tiredness, listlessness, insomnia, failure to exert forcefulness, addiction to physical substances like alcohol and so on are all assimilated to the category of the physical, as are such manifestations as irritability, anxiety, or any other emotional reaction, so long as they can be regarded as derivatives of physical fatigue, physical strain or poor physical health. In their search for the most direct, concrete causal chain of events possible, people who use this point of view could extend it to include such emotional difficulties as may appear to revolve around the individual's physical equipment or appearance, so that problems which centered on the individual's self-conceptions might also be seen as physical rather than mental whenever the individual's feelings were apparently organized around (and, therefore attributed to) a physical element like deafness, short stature, overweight or unattractiveness. At the same time as the non-organic view of mental illness tended to exclude as physical many emotional symptoms, a complementary effort to define "the mental" in positive terms led--through an identification of "mental" with "mind" and "mind" with "thought"--to a stress on disordered thought processes or cognitive and intellectual disorders as the main characteristics of mental illness.

While this definition of mental illness as non-organic seems, at first sight, in complete contrast to the preceding organic definition, they have, in fact, a good deal in common. Both emphasize the term "illness" in the phrase "mental illness," the one because mental illness

is defined as an illness like any other, the other because it is defined as those illnesses and disorders which remain when physical illness and disorders are subtracted. Both, therefore, focus on acute changes in the individual's personality and behavior as the distinguishing criteria of an illness and tend to exclude from the category of illness, almost by definition, chronic, habitual or characteristic personality or emotional trends. These conceptions of the nature of illness alone result in a tendency for either usage to exclude from mental illness most of the personality disorders except for acute neurotic episodes, and this effect is reinforced, in the organic case, by positive emphasis on the cognitive symptoms of brain disease, and, in the non-organic case, both by the emphasis on mental functions and by the exclusion of the many psychosomatic and accompanying emotional symptoms from mental illness. As a consequence, both have the effect of removing mental illness from the field of personality altogether, rather than requiring an accommodation of popular theories of personality to the explanation of both normal and abnormal personality manifestations.

While the two usages have somewhat the same implications for conceptions of mental illness, they are at base mutually incompatible. The organic disease conception of mental illness may, for example, equate mental illness with malfunctioning of the nervous system, but the non-organic usage of mind-body dualism assigns the nervous system to the realm of the physical. It is only by assigning the mental functions to certain portions of the physical organism which are thereafter regarded as "mental" rather than "physical" that the two can be accommodated, but this is, at bottom, a return to the organic definition. It was probably some such dilemma as this which led a few people (four

per cent) to assign the nervous system independent status as a third category inserted between mind and body--for example, the person who said a "nervous breakdown" "affects the nervous system more than the physical or the mental." The nervous system, like the mind was "mental," but like the body was "physical," and was, therefore, not quite either.

The organic conception of mental illness also differed from the non-organic in offering a popularly acceptable account of the causes of mental illness, while the latter tended to leave mental illness unexplained. Given the pragmatic, behavioristic emphases in American thinking, pure mind-body dualism, in which the two are coordinate categories, was not the characteristic statement of "the mental" as "non-physical." Instead, "the physical," in being more concrete, tangible and externally apparent, tended to be identified as more "real" than "the mental," and was, therefore, given precedence over it. In fact, the position has been defined here in a way intended to emphasize the residual rather than coordinate relationship of "the mental" to "the physical." This way of separating "the mental" from "the physical," however, closely approximates a separation into the unreal, uncaused or unexplainable, on the one hand, and the real, caused and adequately explained, on the other. It is for this reason that it is difficult to distinguish the non-physical conception of mental illness from the next usage which centers around the nature of reality, just as both versions are less able to account for mental illness than the organic approach is.

3. A third approach is to define mental illness within the context of the total explanatory scheme applied to human personality and behavior, but only as a residual category to which are assigned those instances of behavior which the general framework cannot otherwise

explain. According to this viewpoint, mental illness is deviant behavior which cannot be reasonably and adequately explained in terms of the prevailing conceptual model. When this formal definition is combined, as it usually was, with the radical-empiricist assumptions of pragmatism--particularly, that the theoretical system of categories used to interpret reality is an accurate, faithful and complete reproduction of reality, mental illness becomes not merely behavior that the popular theories of personality cannot adequately explain, but behavior that is outside of reality and intrinsically inexplicable. This position is exemplified in the views of people who said, quite directly, that they had to call some instance of behavior mental illness because they could not think of any other way of accounting for it; and, quite similarly, people often exempted from mental illness instances of behavior for which they could adduce external, realistic, causally-adequate accounts of their origin. If people who said they called an example mentally-ill because his behavior had no real causes or was "all in his mind" or "only mental" are also regarded as associating mental illness with the unreal or inadequately motivated, then 61 per cent of the American public expressed this view in one fashion or another. When this position is taken together with the mind-body position which shared with a tendency to equate the mind or mental illness with the uncaused or unreal, 74 per cent of the public may be said to have dealt with mental illness in terms of this underlying image of inexplicability.

Since mental illness is, in this view, behavior which fails to conform to reality--or to the popular image of the realities of human behavior, its main characteristics emerge as the opposite of the picture of human behavior derived largely from the direct, equivalent conditioning model. It is, first of all, behavior which deviates from this

scheme and, particularly, deviant behavior which appears inappropriate, unreasonable and irrational; that is, behavior which cannot be understood and explained in the light of its concrete, external, immediately-related antecedents. In its failure to follow the ordinary cause-and-effect scheme that people applied to human behavior, it is, furthermore, behavior which is essentially unpredictable and uncontrollable, since prediction and control presuppose an explanation or understanding of the behavior.

It may be noted that this conception of mental illness is unlike the two preceding in that mental illness is, in this usage, one of the categories of personality analysis and is, thus, brought inside the general scheme applied to human behavior, rather than left outside of it as an illness. Nevertheless, the fact that mental illness is introduced as the category residual to the scheme means that this way of looking at mental illness also leaves the popular views of normal personality determinants separate from and unmodified by views of mental illness. The splitting of mental illness from normal behavior on the basis of the adaptability of popular interpretations to is explanation means, in fact, that the popular theories are self-confirming. No exceptions can arise to challenge the tenability or require the modification of the rationalistic model of normal human behavior, because the exceptions are, by that very fact, assigned to the category of mental illness, to which the rational explanations do not, by definition, apply.

While the verities of commonsense understanding of human behavior are, as a result, unassailably preserved, this approach almost inevitably results in an image of mental illness which is extremely frightening.

In the first place, mental illness is defined as the very opposite of the rational, reasonable image of the behavior of themselves and others which people accepted so strongly. As such, it can almost be said that the counterimage of mental illness was a projection away from themselves of sensed but denied human tendencies which people feared and distrusted. In addition, this approach to mental illness gives it the aura of an intimidating mystery, since there is no way to account for mental illness, consistent with the basic requirement that mental illness be applied only to behavior which is unintelligible and inexplicable. Despite the fact that this usage appears, formally, to conceive of mental illness as a personality or behavioral deviation rather than an organic defect, its major features, like those of the two preceding ways of conceiving of mental illness, also conduce in practice to an exclusion from mental illness of most of the personality and emotional disorders short of psychosis. A recapitulation of the central features attributed to mental illness in this usage--its complete alienness from normal behavior; its unreasonable, irrational, inexplicable quality; and its uncontrolled, unpredictable nature--almost automatically evokes an image which suggests psychotic behavior and which is at the same time exceedingly difficult to rationalize with typical neurotic behavior.

4. The last of the major ways of defining mental illness derives from premises about the role of free-will and determinism in human behavior, in relation to which questions of self-control and moral responsibility become the central considerations. Once the question of control or responsibility is brought to the forefront of attention, two very different images of mental illness result,

depending on the relationship assumed between responsibility and mental illness. Thus, mental illness may be defined as disapproved or socially unacceptable behavior which is outside the individual's conscious control or volition and, therefore, not his moral responsibility. Contrarywise, it may also be defined as disapproved or socially unacceptable behavior which results from the individual's willful failure to fulfill his moral responsibilities or to exercise self-control and self-discipline.

The definition of mental illness as lack of moral responsibility may be seen in positive form, though somewhat indirectly, in the views of 21 per cent of the public who emphasized a lack of rationality or control as the distinguishing characteristic of mental illness. The same viewpoint is more directly expressed, though in negative form, in the position sometimes taken by 28 per cent of the American public, who reasoned that behavior which the individual involved could and should alter for himself (or, in the case of the child, which could be altered for him by physical chastisement) represented moral defect rather than mental illness. The opposite view that moral weakness--self-indulgence, lack of self-discipline, willful failure to exercise self-control--was the essential characteristic of mental illness appeared positively in the views of 14 per cent and was implied in the statements of 11 per cent who exempted from the category of mental illness behavior which was regarded as too ingrained in the individual's personality to be within his conscious control and of 19 per cent who excluded from mental illness behavior for which moral responsibility or blame was assigned to someone other than the individual whose behavior it was. With an allowance for the overlapping of these different ways of asserting or implying that mental illness was characteristically moral weakness, 37 per cent of the public turned to this conception

of mental illness at some point in their discussion, while at least 28 per cent formulated mental illness in terms of lack of moral responsibility.[19]

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[19] Although an emphasis on lack of rationality and control has just been referred to as suggesting the latter conception that mental illness was behavior for which the individual was not morally responsible, people who used this criterion without the more clearcut exclusion from mental illness of behavior within the individual's control are not included in the percentage cited. They are omitted because this symptomatic characterization of mental illness, although logically necessary to a conception of mental illness in terms of lack of responsibility, is, like other descriptive definitions, insufficient to define the position. As has just been indicated, the presumption that mental illness was inexplicable behavior implied much the same kind of characterization.

Although these two positions on moral responsibility lead to contrasting definitions of mental illness, they are based on an identical concern. For any single example, people who were thinking in terms of either of these ways of looking at mental illness were generally agreed that the behavior in question was morally reprehensible or a sign of character defect, remediable by the individual. They disagreed only with respect to the labels to be applied to moral weakness. Where mental illness was defined as weakness of character, it became another term used to stigmatize and condemn the individual concerned; the reverse definition was equally critical of the behavior, but exempted it from the category of mental illness, perhaps because use of the term "illness" might imply excusing or condoning it. Indeed, it may be recalled that it was exactly this kind of disagreement over the classification of moral defects which resulted, in the case of "Bill Williams'" alcoholism, in a good deal of similarity between the formulations of people who called his problem mental illness and those of people who labeled it a flaw of character.

With the practical emphasis on action, control and change of behavior which ran through American thinking and the related reliance on sequences of causation which, though highly determined, were also highly adapted to intervention in or reversal of the process to alter expected consequences, a large part of emotional, personality or character trends could be viewed as undetermined or determined in ways which still left them within the individual's conscious ability to control. It may be said, then, that an identification of mental illness with behavioral manifestations outside the individual's control once again was tantamount, in practice, to a limitation of mental illness to the psychoses. The reverse approach, which identified mental illness with these manifestations of individual perversity, was the only major conception of mental illness conducive to the inclusion of personality and character disorders within the category of mental illness, but the logic by which they were included in no way altered the basically moral approach to them.

Both of these definitions of mental illness by reference to the moral qualities of the behavior are agreed in considering mental illness a term referring to certain varieties of human personality, so they each raise questions of rationale by which they are to be accommodated within the general interpretive scheme applied to human behavior. In the negative statement which excluded from mental illness behavior over which the individual had control, the behavior regarded as other than mental illness was voluntary and the usual determinist explanation did not apply. The fact that reasonably determined behavior was often regarded as not mental illness at the same time as the free actions of the individual were also assumed not to be mental illness may raise a

problem, since these views, taken simultaneously, excluded determined behavior from mental illness and suggested that it was determined behavior. These two views can be resolved, however, by identifying mental illness with behavior determined by organic brain disease rather than by life experience, so that the ordinary determinants of personality did not apply to mental illness, which became, once again, a category unrelated to personality analysis. On the other hand, it was only by implication that behavior over which the individual had no control was determined, so this view could combine more directly with the idea that mental illness featured behavior that had no reasonable determinants to a position which simply underlined the inexplicability of behavior that had the coerced quality of the completely determined without having any adequate causes.

The alternative moral conception that mental illness was disapproved behavior for which the individual was responsible also fitted very well and directly with the view that it was uncaused behavior which could not be explained within the same scheme as normal personality traits. As has already been indicated in the discussion of the paranoid behavior of "Frank Jones" (Chapter 4, pp. 27-28), it was possible to adduce the usual, direct conditioning accounts of the origin of emotional tendencies classified as mental illness, provided the conditioning experiences were regarded as their starting point rather than their complete determinant. In this version, conditioning produced the individual's initial reaction to his experience but he was free to control the extent of its influence on him. If he then chose or were weak enough to permit the conditioning experience to coerce his behavior, he had a character defect which led him to behavior unreasonably, and

his willful irrationality, although not the original conditioning itself, could be regarded as mental illness. In every one of these instances, mental illness, even though a personality category, was defined in such a way that the schemes which accounted for the origins and persistence of normal human behavior and personality need not be called upon to explain the abnormal.

As the discussion so far has indicated, assumptions about the nature of reality, the relations of mind and body and the role of determinism and freedom in human behavior were the primary non-descriptive considerations used in defining mental illness. For all but 12 per cent of the American public, whose definitions were either exclusively descriptive, or a combination of description and treatment,[20] behavior of whatever character was mental illness only if it was, alternatively, an organic brain or nervous system impairment; a "mental" or non-physical manifestation; an inexplicable, uncaused response that bore no relation to reality; an indication of defects in the individual's volition; or an instance not subject to individual self-determination. The proportions of the public who rather explicitly expressed each of these views of mental illness were:

[20] This figure is different from the 16 per cent shown in Table 41, because the category "weakness, self-indulgence, failure to exercise self-control is mental illness" was shifted from the classification of descriptive character, to which it was assigned in Tables 27 and 41, for the purposes of this analysis.

Mental illness is:

An organic disease	20%
A non-physical disorder	32
Counter-reality, inexplicable behavior	61
A volitional defect	37
Involuntary action	28
Purely descriptive category	12

Regardless of which of these criteria was employed, about half added the further qualification that behavior which otherwise fitted the definition was not mental illness, if it could be easily changed or was amenable to lay correction, or was mental illness, if it was difficult or impossible to correct it and required professional intervention. (Tables 27-28.) The proposals for corrective action in each instance, previously shown in Tables 31-32 and presented in comparative form in Table 43, incorporate all statements about treatment, whether these were intended to define mental illness in terms of treatment, implied a particular causal approach to its definition, or were not directly relevant to defining its basic nature. Nevertheless, the corrective solutions proposed fitted very well with the major causal premises just discussed. In general, the concrete solutions most often proposed for behavior that was not regarded as mental illness were, first, the practical one of correcting the assumed reality situation to which the behavior appeared to be a reasonable response, and, second, the moral one of discipline or self-discipline. These were, of course, direct expressions of two rather frequent causal postulates: that behavior which was a reasonable response to its conditioning circumstances was not mental illness and that behavior within the voluntary control of the individual was not mental illness. In either case, the individual's problems could be corrected by himself or by anyone in a position to alter his current life situation, so that the definition of mental illness in terms of a treatment criterion which excluded behavior that was easily altered by lay action was not so much an added criterion as an immediate implication of the counter-reality and moral views of mental illness.

Quite similarly, the statements people made about the treatment of mental illness flowed consistently from these views of mental illness as either inexplicable and uncontrollable or morally reprehensible or both. First of all, the suggestion that the behavior in question was a situational problem to be resolved by changing the conditioning circumstances was almost never made for behavior that was regarded as mental illness. (Tables 32 and 43.) At the same time, the possibility of self-help, though rather frequently mentioned in connection with mental illness, was disproportionately a non-mental illness solution. Self-help as a way of correcting mental illness was, in fact, most likely to be mentioned in connection with those examples--"Bill Williams," "George Brown" and "Mary White"--whose behavior was most amenable to inclusion within the category of mental illness when mental illness was regarded as a personal shortcoming; and popular reliance on this kind of a formulation, whenever mental illness was extended to include non-psychotic emotional disorders that were not overtly anti-social, is demonstrated by the fact that, for "George Brown" and "Mary White," self-help was emphasized even more by people who classified them as mentally-ill than by those who did not.

In contrast to the emphasis on the solution of realistic problems and the exercise of self-control in dealing with behavior that was not mental illness, the control of mental illness more typically required either the professional assistance of psychiatrists or other physicians or the psychological intervention of family and friends, usually in the form of rational persuasion or exhortation. The suggestion that professional treatment was needed to cope with certain behavioral problems was almost exclusively reserved for behavior regarded as mental illness.

for example, psychiatric treatment was proposed for 32 per cent of the examples classified as mentally-ill for whom some treatment suggestion was made, but for only two per cent of the examples where action recommendations were made for behavior that was not mental illness. This emphasis on the need for professional advice in dealing with mental illness suggests, once again, the view that mental illness was imexplicable behavior; that is, it was not amenable to the usual control measures applied in interpersonal dealings in daily life, but its correction required, instead, highly specialized professional training and skills. Nevertheless, professional assistance was not the most frequent corrective approach to mental illness, except in the case of the violent paranoid, "Frank Jones." The tendency was to substitute for professional help either self-help, with the moral approach to mental illness it implied, or lay help from family and friends. The latter form of treatment was largely, though not as completely as professional help, appropriate only to mental illness and not to other forms of behavior, and in it the moral and inexplicable views of mental illness tended to merge. That is, the suggestion was that the behavior of a person who was acting in the unreasonable and inappropriate manner defined as mental illness could be altered, if someone close to him pointed out these characteristics and suggested, advised or urged him to change. This approach to what has been defined as the highly irrational pinpoints the inherent limitations of the dominant popular approach to human behavior, in which the only means available for dealing with any kind of behavior were the rational, reasonable approaches of pragmatic commonsense. Because of this overevaluation of the role of rationality and control in behavior, the only way that behavior which violated this scheme and

was, therefore, defined as mental illness could be corrected was by rationally persuading the person to abandon his irrationality and act again in conformity with the usual scheme. This procedure necessarily entailed the assumption that the individual had free control over behavior that was not determined by reality, could alter it if he would, and would want to, if he were brought to realize the inappropriateness of his conduct. The essentially moral outlook necessary to the pragmatic action scheme combined with the highly concrete and rational conception of reality on which it is based thus resulted in a kind of ambivalence in popular approaches to psychotherapy. On the one hand, it was addressed to the irrational and inexplicable, which was better left to professionals who could understand it, but, on the other, it involved, primarily, a process of reasoning with the unreasonable individual, which could be carried out by anyone. The question of popular conceptions of psychiatry and psychotherapy is discussed more fully in a later chapter, but, as suggested here, the inability to explain or deal with irrationality within the framework of the popular approaches to human behavior resulted in an implicit assumption of rationality, whenever it was necessary to deal with irrational behavior, so that the process of psychotherapy appeared as a highly rational one to which lay counsel was a reasonably exact approximation.

This digression into the relation between corrective measures and underlying formulations of the basic nature of mental illness illustrates the fact that the positions which have been outlined did not figure in popular discussion as fully explicit, consistently applied criteria of mental illness. They were, rather, persistent themes that energed obliquely from what people said and were interwoven into their

remarks as half-formulated, unexamined premises whose mutual compatibility and individual correspondence with fact were not directly in question. As a result, relatively few people (16 per cent) depended, entirely, on any one of them. Some attempt has already been made to indicate how these positions could be consistently reconciled, so it will not seem exceptional that 85 per cent of the group who sometimes defined mental illness as a defect of volition also saw it as behavior that was uncaused or unrelated to reality, or that 39 per cent of those who defined it as non-physical at other times formulated it as a character weakness, or that all of these conceptions easily joined with the idea that behavior was not mental illness unless it was difficult to treat and required professional handling. What is more remarkable, however, is the fact that among the group who defined mental illness as an organic brain disease, 23 per cent also defined it as non-physical; 49 per cent, as a moral weakness of character; and 59 per cent, as behavior which had no "real" causes. And, similarly, 40 per cent of those who exempted from mental illness behavior for which the individual was morally responsible also defined mental illness, at other times, as moral weakness.

More important, perhaps, was the fact that most of these premises were untenable, within the logic of the people who used them, and were abandoned and contradicted whenever the discussion approached directly such topics as the causes and treatment of mental illness, apart from their role in defining it. One basic problem was that the leading conceptions of mental illness--counterreality, non-physical, and even, moral--all fitted together very well and all tended toward the position that mental illness was undetermined behavior for which no adequate

causal account could be found, except, perhaps, in the "mind" or "will" of the mentally-ill person. At the same time, people's general views were, as we have seen, highly determinist, so it was difficult to adhere consistently to a view that mental illness had no causes or only inherent psychic causes. And, when people attempted to outline the causes of mental illness, the only categories of causation available were those which had also been used to define behavior that was not mental illness. Similarly, the conception that mental illness must be difficult to treat was opposed to the underlying optimism about the possibilities of control and alteration in pragmatic views of human behavior. When they were not defining mental illness, people tended, therefore, to return again to a view that behavior was easy to change and, to outline, as methods for treating mental illness, procedures whose efficacy with normal behavior had been cited as a criterion for distinguishing mental illness from normal behavior.

The extent of this self-contradiction was far-reaching, with exactly four-fifths of the public directly violating their own premises part of the time. Thus, over ninety per cent of the people who felt that behavior which had "real," causally-adequate, or reasonable origins should not be classed as mental illness at other times advanced exactly the same kind of explanation of behavior that they did consider mental illness. For instance, the same person, speaking of "Frank Jones," said he was not mentally-ill because "circumstances could have caused it, so he could be perfectly sane," but, speaking of "George Brown," who was regarded as mentally-ill, said, "That was probably caused by his environment--something could have happened to a friend. (C) Losing a job or some other loss--a car wreck or a

financial loss." Or, similarly, two-thirds of those who sometimes exempted "the physical" from mental illness at other times gave physical causes for mental illness, and the nervous system moved back and forth in a related way. Illustratively, one person said a "nervous breakdown" was not mental illness "because you could have a physical ailment causing that trouble," but asked about "Frank Jones," said immediately that he was mentally-ill and added, "It could be a physical ailment that caused it--drinking too much, venereal disease, pellagra, or even overwork and nerves can cause a mental illness." In the same way, four-fifths of the people who said they regarded immoral behavior as outside the realm of mental illness at other times referred to moral weakness as mental illness, and the status of the ingrained behavior as outside the individual's control shifted in similar fashion. For instance, one person said "George Brown" was not mentally-ill because "With a little control he could help himself. He needs to exercise some self-control," but "Bill Williams" was mentally-ill because "Weakness is an illness. He needs to exercise self-control instead of letting himself go." Or, in another instance, "Betty Smith" was not mentally-ill: "No, it's not her fault! If they had played with her more and taken more trouble with her when she was little, she wouldn't have been that way in the first place"; but "Frank Jones" was mentally-ill, even though the person said, "He can't help feeling that way. In his childhood, he was probably always neglected and had to give in a lot to a younger child."

Essentially similar instances of these kinds of inconsistencies could be multiplied many times over, since they were the rule rather than the exception in popular discussion. Instead of extending these

quotations, which do no more than illustrate the leading types of self-contradictions reported in Table 44, a better idea of the sources of these illogicalities can be gleaned from examining an interview as it developed, rather than viewing pieces of it out of context. Since this is a rather lengthy procedure, only one interview will be presented in detail, and an atypical one has been deliberately selected to point up the paradoxes that emerged. This is an interview with a woman whose sophistication, interest and experience were well above average. She was a college graduate, married to a professional man in comfortable circumstances, mother of several children, and she indicated elsewhere in the interview a concern for and voluntary work with child guidance programs. Her obvious familiarity with the subject matter, immediate recognition of non-psychotic mental illnesses, and emphasis on psychodynamics were all at variance with the general level of popular discussion, and, against this background, her failure to be consistent with her own logic cannot be dismissed.

This woman began by describing mental illness generally in apparently non-psychotic terms:

> I think they just aren't able to cope with the realities of life in a normal way. I don't think of them as insane. (C) They just don't have a normal reaction to everyday living; they are inadequate in facing simple problems.

Her discussion of the "non-insane" mentally-ill continued consistently along these lines:

> It is an emotional adjustment they don't make. Jealousy and envy and lack of appreciation of what they have themselves. (P) They are irritable and lack a spirit of cooperation, and they are very critical. (C) Of friends, especially if the friend has any great talent or social position or is liked better than they. They are destructive in their criticism.

Finally, she said of "nervous breakdowns":

> I don't think there is any such a thing as a nervous breakdown. (C) They are emotional upheavals, lack of control of their emotions, caused by something physical or a crisis in the family or social life or financial crisis. I don't call it a nervous breakdown, just a lack of emotional control.

But, she concluded, whatever you called it, it was mental illness, because it was:

> A lack of a normal reaction to a very normal problem. (C) A normal response is optimistic, buoyant and having a feeling of confidence in handling a given situation. He just has no fear of the outcome.

At this point, then, she was classified as adhering to a consistent and spontaneous inclusion of non-psychiatric syndromes in mental illness, and her general definition of mental illness appeared to be that it was a deviant emotional response to or a distorted perspective on reality.

With this usage it might be expected that this was one of the exceptional persons who regarded all of the examples as mentally-ill, but, quite the contrary, in her view, only the violent paranoid was mentally-ill. Speaking of "Frank Jones," she said:

> I think that in his youth his emotions had very little guidance. He had definite insecurity. (C) He lacked success, maybe in his school, his athletics or his adjustment to his family. He just has had no success in his life. (C) I think it was due to his early training. (C) In his early training, either the standards were too high and he could never attain what was expected of him or he never felt that he was wanted or necessary, either in his family or in a gang.

And, consistently with what had gone before, she concluded that he was mentally-ill because "He doesn't have what we call a normal reaction to everyday living conditions."

"Betty Smith," however was not mentally-ill, although something was wrong:

> (S) Yes, I would say that she had an emotional disturbance. (P) It is due to insecurity, I think. (C) She has never made the right kind of social adjustment. (C) She may have been a victim of too much criticism, or she may have felt as a child that she was never wanted. (C) Broken home, and parents quarrelling and lack of love may have caused her not to feel secure with anyone. With quarreling, she may have felt ashamed and not wanted any of her friends to come into her home, and that has become a mental habit.

This was not mental illness because "It is her habits and emotional conditioning to life that has been wrong."

Of "George Brown," she said:

> (S) Yes, I think there is something wrong with him, but I don't think it is mental. (P) Lack of success as a child and lack of security. (C) Every person wants to be wanted and express himself as an individual, and he wants those ideas accepted, and, when he doesn't have any of those things, he thinks the whole world is against him. (C) Due to his parents not accepting their position in life and being vocally critical about it to the child. Maybe they were always saying, "Look what the Jones have and we don't have it," or telling him some other boy was on the football team and why wasn't he on it, or why did someone else get better grades, and as a result of this, he has never felt secure in life.

"Brown" was not mentally-ill because "He is only dissatisfied; he can function as a normal person in society; he doesn't break the laws or anything."

"Bill Williams" also had something wrong:

> He is just unable to discipline himself. (P) I think every child is born with will power, but it is dormant until it is exercised, and he just never exercised his will enough to discipline himself. (C) In his guidance by his parents, he wasn't helped to form the right habits of discipline. (C) Drinking is a habit he has formed. It might be wrong associates, or he has seen it in his home and just accepted it.

Alcoholism was not mental illness because "I think it is just a weakness in his will power."

With "Mary White's" compulsiveness nothing was wrong:

> I think she has a fear complex. She may have had overly cautious parents that watched her constantly. (C) She is never sure of herself and has a feeling of insecurity due to not enough responsibility in her childhood and early adolescence. The elevator is due to fear, too. (C) She may have been frightened, maybe her mother or father held her tightly and said, 'I'll take care of you,' or there may have been a jarring that frightened her. She has been overly protected.

And "Bobby Grey's" delinquency prompted these comments:

> I think he has formed bad habits due to training by his parents. (C) He wants satisfaction, and he has found he can get it by cheating, lying and stealing. Maybe his parents want him to get "A" grades in school, and he isn't, so he lies. This gives him a feeling of importance even if it is contrary to what he knows is right. In school maybe he couldn't attain the success that satisfied him, and, as long as he wasn't recognized as the best, he went to the other extreme and assumed an attitude of indifference and, almost, pugnacity. (P) Maybe he told a lie, and they didn't help him understand it was wrong, and it made him feel important, and he told another one. Maybe he stole something, and his parents told him he shouldn't have done it, but didn't make him take it back.

She concluded that "Bobby" was not mentally-ill, since she thought "his behavior absolutely normal for a child who hasn't had the proper guidance."

And, to round out this presentation, in answer to a subsequent question which inquired into the causes of less severe emotional illnesses generally, she said,

> Childhood patterns of life: not being adjusted and feeling insecure because he isn't loved and wanted, and he is criticized, and so he is never comfortable as a child, emotionally.

It is certainly apparent, in this woman's interview, that causal premises and redefinitions of mental illness were introduced as afterthoughts to rationalize less rationally derived feelings that the person under consideration was not mentally-ill. And it was at this point that the self-contradictions began: "Mary White" was not mentally-ill because her disordered emotional response was attributable to her "conditioning to life," even though exactly this same kind of "conditioning to life" was the only cause of mental illness; "George Brown's" emotional deviancy did not qualify as mental illness because it was not carried to the point of violence or crime, even though preceding discussion of mental illness generally had not required such extreme symptoms; "Bill Williams'" "weakness in will-power" was distinct from mental illness, although mental illness included "a lack of emotional control"; "Bobby Grey's" reactions were a reasonable response to the parential circumstances in which he found himself and not mental illness, even though mental illness was, itself, the expected response to certain parental practices.

As this illustration and the essentially similar character of the many other instances of illogical, contradictory reasoning suggest, the kinds of premises people introduced into their definitions of mental illness were not so much the source of their logical difficulties as they were both the result of widespread attempts to avoid the conclusions that flowed logically from their own definitions and the culturally-available means by which that avoidance could be achieved. It is true, as indicated, that people got into logical difficulties with each of the main conceptions of mental illness they used, inasmuch as they appeared to require more than one such conception to deal with even a

limited range of instances, and they did not at all times find the premises inherent in them acceptable versions of the nature of reality. But, even when the premises on which it rests are actually contrary to the facts of human behavior, there is nothing inherent in any conception of mental illness to prevent its consistent application, if only as a logical exercise. The inconsistency with which these conceptions were, in fact, applied is, therefore, in its own way, evidence that these were not the systematic starting-points from which people's reasoning began, but were convenient handles, supplied by the cultural heritage, for which people reached out whenever they needed support.

That both the underlying premises and their inconsistent and self-contradictory use served to avoid labeling behavior mental illness can be demonstrated from the data more systematically than has thus far been attempted. To put it most simply, the people whose descriptive definitions of mental illness were, in principle, most logically amenable to the recognition of non-psychotic syndromes were, in fact, the people who were most likely to introduce causal premises and most likely to violate these premises logically. And, in turn, logical contradictions generally resulted in a failure to recognize non-psychotic behavior as mental illness. If recognition of at least "George Brown" and the two psychotic examples as mentally-ill is taken as an index of extending recognition of mental illness to non-psychotic syndromes, then, as we have seen, people whose general usage consistently included non-psychotic syndromes and people who defined mental illness as emotional or functional deviancy were also most likely to recognize non-psychotic syndromes in practice. Within each definitional-usage group, however, people who contradicted themselves were less likely to recognize such syndromes than were people

who adhered to the logical requirements of their usage:

	Proportion Recognizing Non-Psychotic Syndromes
Mental illness descriptively defined as EMOTIONAL-FUNCTIONAL DEVIANCY and	
General usage consistently included non-psychotic syndromes	
No logical contradictions	30
Logic contradictory	24
General usage did not consistently include non-psychotic syndromes	
No logical contradictions	19
Logic contradictory	15
Mental illness descriptively defined as COGNITIVE-CONTROL or GENERAL DEVIANCY	
General usage consistently included non-psychotic syndromes	
No logical contradictions	10
Logic contradictory	7
General usage did not consistently include non-psychotic syndromes	
No logical contradictions	4
Logic contradictory	3

And, it may be added that within the groups whose definition of mental illness was in terms of deviant emotional response, people who introduced causal premises were less likely to classify such syndromes as "Brown's" as mental illness, even when they did not contradict the logic of their premises. Thus, the counterpart of the first figure above is 37 per cent for people who defined mental illness solely as emotional deviency, but 25 per cent for people who added causal criteria to this definition. In sum, causal premises were most frequently introduced by people whose usage otherwise required their viewing such persons as "Brown" as mentally-ill, and their introduction did decrease the likelihood

of recognizing these mental illnesses. Correlatively, these causal premises were also most frequently abandoned and contradicted by this same group and, from the fact that this kind of contradiction shifting also lessened the likelihood of recognizing non-psychotic mental illnesses, it appears that they were abandoned in favor of others whenever they did not serve to deny mental illness.

This kind of conclusion is, in one sense, almost apparent from the very nature of the thought system itself. For the interesting thing about all the popular attempts to define mental illness in terms of non-descriptive criteria is that they shifted attention from the more immediate, concrete behavior to the more indirect and more hypothetical causes lying behind it and, by so doing, raised issues that were indeterminate. That is, the considerations raised by each of the major popular conceptions of mental illness were such that the essential factors necessary to decide whether or not any concrete instance of behavior was mental illness were neither inherent in the behavior itself nor incontrovertibly demonstrable from it. As a result, they could not, of themselves, require a conclusion that certain behavior patterns were mental illness and others not, but rather equally justified whichever conclusion people reached. Take, for example, the pattern of anxiety and tension consistently exhibited in the behavior of "George Brown." One could postulate damage to some nerve center as the cause of his behavior and call him mentally-ill or deny the presence of organic involvements and not regard him as mentally-ill. With emphasis on the tension symptoms, one could call his behavior evidence of physical fatigue or illness or, alternatively, trace the physical manifestations to a prior mental source in emotional fatigue or strain and call it mental

illness. One could postulate realistic circumstances to which anyone would respond with some degree of anxiety and consider "Brown's" behavior reasonable under the circumstances or, denying any correspondence between "Brown's" reactions and reality, conclude that he was mentally-ill. Or, one could assume that he chose to be this kind of a person or failed to exercise the self-control necessary to be different or, conversely, that his behavior was outside the area of his intentions and efforts and not subject to his control, from either of which assumptions it equally well followed that he was or was not mentally-ill.

The qualities of this kind of reasoning are not too far removed from the kind of folk wisdom epitomized in proverbs, where there generally exist at least two contradictory sayings on any subject, so that any instance to which the first is not applicable is surely covered by the second. Such pairs as "Absence makes the heart grow fonder" and "Out of sight, out of mind;" "He who hesitates is lost" and "Look before you leap"; "Not everything that glitters is gold" and "Fine feathers make fine birds"; or "Birds of a feather flock together" and "Opposites attract"; all contradict one another. Since only the appropriate one of any pair is ever selected and applied to a single concrete instance, however, the contradictory nature of these principles need not be explicitly recognized or reconciled. And, similarly with the discussion of mental illness: at any one point in their discussions, people appeared to be judging concrete instances by referring them to one or another of these premises about human behavior, but, in the course of the discussion, these premises were used in the same ad hoc manner, adopted for an instance to which they seemed applicable and abandoned when they did not. The outcome was that, while people appeared to be

adhering to logical considerations, they actually shifted ground repeatedly, with abundant but unconfronted self-contradiction.

The result of this kind of thinking about mental illness is that the term had no fixed referent in popular discourse. It was shown, initially, that only 35 per cent of the public maintained an internally consistent conception of the syndromes to be included within the category throughout a relatively brief discussion of mental illness in the abstract. (Table 10.) Of this group, moreover, close to a quarter explicitly contradicted their previous usage or redefined terms as they discussed the six examples.[21] (Table 45.) And, of the 27 per cent who remained,

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[21]This figure takes no account of which examples were classified as mentally-ill and which not, a matter which usually involved implicit inconsistencies. It takes account only of the inconsistent use of terminology in the course of classifying the examples.

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close to four-fifths became involved in the contradictory logic which has just been discussed, as they restated the defining criteria of mental illness. At the close of their discussions of the six examples, then, six per cent of the public had adhered with complete consistency to any conception of mental illness--two per cent to a usage that limited the term to psychosis and four per cent to one that consistently included non-psychotic manifestations. (Table 46.)

The effect, if not the intent, of the vacillating way in which people defined and used the term, mental illness, was that only the image associated with popular stereotypes of psychosis remained a fixed and unchanging element in it. All of the inconsistencies in usage as well as the criteria used to define mental illness or to distinguish its psychotic forms from non-psychotic mental illness worked, as we have

seen, in the direction of the equation of mental illness with psychosis and the subsequent recognition as mental illness of only the violent syndrome typified by "Frank Jones." The illogical lengths to which so many people went to avoid calling a person mentally-ill (and it should not be forgotten that the same avoidance was frequently achieved without formal violations of logic, since only 37 per cent of the most logical and most favorably-disposed usage group consistently included the non-psychotic behavior of "George Brown" as mental illness) could only have resulted from the equation, in practice, of mental illness with extreme forms of psychoses and either an awareness that the person in question was not psychotic or a reluctance to call him psychotic, even if he appeared to be.

The difficulties in popular thinking that resulted from this elision of mental illness into psychosis have, thus far, been treated primarily as logical problems, but it is obvious that they implied psychological difficulties with the concept of mental illness, as well--emotional needs in whose service logical thinking was popularly sacrificed. To account fully for the popular tendency to revert to an image of extreme psychosis in thinking about mental illness, it is necessary to remember that these psychotic manifestations were, historically the first and, until rather recently, the only forms of mental illness recognized and that around them developed an emotional aura of threat, horror, fear and avoidance. The historical priority of psychoses and the emotional climate surrounding them may, perhaps, themselves, be viewed as results of the kinds of culturally-pervasive assumptions about human behavior already examined. These, as we have seen, placed a heavy premium on rationality and control as the distinctive characteristics of

normal human behavior, in relation to which any loss of rationality and of cognitive control--a potentiality of every psyche--assumed overwhelmingly threatening emotional proportions. Psychoses, as disorders of rationality and control, violated these basic norms of human behavior in ways that could not fail to be immediately perceptible; and, as actualizations of the ever-present threat, they had the same emotional significance--to be stigmatized, rejected and avoided.

It is exactly these emotional connotations attached to psychosis or mental illness that made it difficult for people to accept fully and adhere to all of the implications of the newer usage of the term, mental illness, when it is used to denote a wide range of psychiatric disorders, most of which do not have quite the same quality of threat as psychosis. At the time of this research, the great majority of the public had encountered this denotation, and their general discussions of the term, mental illness, reflected this intellectual awareness to greater or lesser degrees. At the same time, the connotations or emotional implications which were evoked by the term were not consonant with this usage. Their first, most immediate emotional response to mental illness tended to be in terms of the threatening image of psychosis, so it was difficult to accept that the many other less threatening emotional disorders were in any way related to it and assimilable under the same heading. Consistency between formal and emotional usage required either the abandonment of the additional content assigned to the category of mental illness or the development of a modified emotional response appropriate to the entire category. Since the latter was not entirely within people's control, they could only, in effect, pursue the former course.

It was the resolution of this kind of conflict between knowledge and feeling that was illustrated by the interview cited at length, in which, it may be recalled, a well-educated, informed woman twisted her original usage of mental illness, at some cost in self-contradiction, away from that of a rather neutral term referring to a broad range of emotional disorders to one which in practice denoted only the violent irrationality of a "Frank Jones." Yet, the concept of psychosis was one which was ominous, mysterious, and frightening to her, while her original definition of mental illness did not contain the same threatening qualities. For instance, she said, later in the interview, that psychoses could never be anticipated and prevented because "the symptoms aren't recognized as ones which point conclusively to a mental disorder," and that she would never be completely comfortable in the company of a former psychotic, since "I would have a feeling of insecurity. I'd feel I couldn't ever depend on her for perfectly normal behavior." Still, reinforcing the extent to which she had departed from her original stress on non-psychotic disorders, she selected as the point at which a person with a mental illness or a nervous condition should consult a psychiatrist the time when "you think the person would do bodily harm either to themselves or someone else."

There is here, in its way, the usual paradoxical circularity of emotional problems, for the very fearfulness of mental illness makes it, simultaneously, something to be kept as remote from self as possible, and, the fewer and more extreme the behaviors classified as mental illness the more alien they will seem from the behavior of most people. But, the more alien, the more fearful; and the more fearful, the greater the need to define them as alien to self, so that both fear and avoidance

themselves operated to perpetuate the fear-provoking, to-be-avoided image of mental illness rather than to encourage adherence to a substitute, more emotionally-acceptable conception. It is for this reason that it may be said that the more closely people's conceptions of psychosis approximated the horror-provoking image, the greater was their inability to accept consistent enlargement of the category of mental illness to include less threatening behaviors, just because the immediate effect of this extension is not to decrease the emotional impact of psychosis but to extend it by association to behaviors which cannot be kept at so far a distance from those of the people concerned.

Almost as a corollary of what has been said so far, in their discussions of the six lifelike examples, people tended especially to move toward a conception of mental illness as applicable only to extreme forms of psychosis and, so, in no way related to their own behavior whenever the examples assumed personal significance. As they heard the description of each hypothetical person people sometimes volunteered remarks indicating that they perceived in this description someone they knew--themselves, family, friends, acquaintances. Roughly two-fifths of the public (42 per cent) made comments of this kind, with 24 per cent referring one or more of the examples to themselves, nine per cent seeing members of their immediate families--parents, siblings, spouse or offspring, four per cent recognizing more distant relatives and 20 per cent perceiving friends or acquaintances. This tendency to identify the hypothetical people with persons they knew emerged in different contexts and had no single meaning. Some people were expressing surprise, amusement or insight into the research devices, as with the man who said, "You know, all you have to do is change their names and I know

every one of them." Others mentioned the similarity between the example and someone they knew as a logical term in the syllogism by which they reached their conclusion about the example; that is, they reasoned that a particular example was just like X, and X ended up in a mental hospital; therefore, the example was also mentally-ill. For instance, people might say, "/He's mentally-ill because/ he's acting just like my brother-in-law did before they took him away." Still others appeared to be arguing from experience in mentioning the resemblance they perceived, but with a more defensive quality which suggested that the basic reason why the example could not be considered mentally-ill was that it would require a conclusion that oneself or someone else close was also mentally-ill, and this suggestion had to be resisted. For example, a woman said, "Well, I do that /check doors/ all the time and there's certainly nothing wrong with me."

While only the fact and not the implications of recognizing someone in the examples was directly preserved, it can be noted that, when experience was called upon to support the conclusion that an example was mentally-ill, it was acquaintances, friends and more distant relatives who were cited, while recognition of self and immediate family members tended to lead to the conclusion that the example was not mentally-ill. The very likelihood of perceiving anyone in an example ranged from six per cent of the public who perceived someone they knew in the most extreme example of paranoid behavior to 24 per cent who recognized someone in "Mary White," whose behavior was least often regarded as mental illness. And, in much the same way, the person perceived in an example was identified as oneself or a member of one's

immediate family by only 25 per cent of those who knew someone like "Frank Jones," but by 89 per cent of those who knew a "Mary White." For any one example, the same thing held true: people who associated the example with themselves or their families were least likely to see mental illness, while people who recognized more distant familiars were even more likely to call the example mentally-ill than those who made no reference to similarities between the examples and their associates. The details may be seen in Table 47, but, by way of summary, when the six examples are combined, the proportion who classified as mentally-ill examples in which they perceived themselves and others were:

Examples Which Were Identified With:	Proportion Classifying Example as Mentally-ill
Self	8%
Immediate family	17
Other relatives	33
Friends, acquaintances	36
No one	30

These data, of course, strongly suggest the need to preserve an image of mental illness which left self and loved ones intact and unthreatened, and this need, itself, necessarily implies that mental illness did pose for people the kind of emotional threat that has been rather summarily discussed here.

Throughout this section, the intent has been to examine popular conceptions of mental illness from the standpoint of their intellectual content, logic and consistency, not because these elements were the exclusive or even the primary factors in popular thinking about mental illness, but simply because they constituted a convenient starting-point.

The emotional significance of mental illness has, as a result, been dealt with thus far only in the cursory fashion necessary to give some perspective to the largely intellectual emphasis. In the next major section, Part III, and, especially, in Chapter 8, these emphases are reversed and attention is focussed on the complex of beliefs, attitudes and feelings which constituted the emotional meaning of mental illness, with only such reference to the more conceptual problems as are needed to interconnect these interdependent aspects of popular thoughtways. Before we turn to Part III and the emotional half of the coin, there is, however, one final aspect of the conceptual analysis that requires some attention. For, as the data just cited in demonstration of popular fear and avoidance of the topic of mental illness also suggest, when issues of threat and defensiveness were not uppermost, sheer experience or first-hand acquaintance with persons known to have been mentally-ill led to clearer or more consistent conceptions of mental illness. After two brief notes which conclude this chapter, we shall, therefore turn in the final chapter of this section to the role of experiential factors such as these in conceptions of mental illness, especially as differences in experience were reflected in variations in thinking about mental illness among different segments of the American public.

The Seriousness of Mental Illness

A good deal of ambivalence entered into people's judgments of the seriousness of mental illness. On the one hand, the fear, shame and avoidance centering around mental illness suggests that it should be regarded as a very serious kind of disorder, and, indeed, just over four-fifths (83 per cent) said, "Important," when asked: "Would you say that

mental and nervous illnesses are an important health problem in the United States today, or aren't they so important?". In support of the importance of mental health problems, however, people generally stressed their presumed high or increasing prevalence and the factors in modern life--like war, insecurity, strain and its rapid pace--believed to account for the growth in number of these difficulties, rather than the intrinsic nature of the disorder itself.[22]

[22] These results are derived from the pretest rather than the main study. See footnote 15, Chapter 3, page 37.

So, it should not be surprising that when people were asked to name the disease they considered most serious in terms of the worst illness a person could have, only one per cent volunteered mental or nervous illness, while 58 per cent mentioned cancer; 14 per cent, heart disease; 13 per cent, infantile paralysis; six per cent, tuberculosis; and eight per cent, a variety of other physical illnesses. In contrast to the actuarial considerations associated with regarding mental illness as an important health problem, over half the adult population (52 per cent) cited the incurability of the disease they had in mind--the fact that the disease was uneradicable and its ultimate outcome was death. And secondary considerations were that the illness was painful and caused extreme suffering or that the illness left residual physical consequences.[23]

[23] The questions asked were: "What would you say is the most serious disease today? (I mean, what illness would be the worst one for a person to have?)", and "Why is (name of illness) the most serious one?"

This emphasis on death, pain and crippling as the elements which make illness serious fitted very well with a tendency to belittle the

seriousness of mental illness, which seldom is a direct and immediate cause of death and which generally produces "only" mental anguish and emotional crippling. Thus, the seriousness of mental illness was more likely to turn on its effects on the non-afflicted than on its consequences for the sufferer. For instance, among the six fictitious characters, only three were regarded as seriously mentally-ill by a majority of the people who thought them mentally-ill at all, and these were the three whose behavior entailed rather immediate danger for others--"Frank Jones," with his violence against strangers, "Bill Williams," with his alcoholic irresponsibility, and "Bobby Grey" with his stealing and delinquency (See Table 15). In fact, two-thirds of those who classified "Frank Jones" as seriously mentally-ill said explicitly that it was a serious mental illness because he constituted a menace to public safety. Similarly, three-fifths of those who classified "Bobby Grey" as seriously mentally-ill pointed to the emergence of criminal, anti-social trends as justification of their judgment. And, the largest single category of explanation of the seriousness of "Bill Williams's" mental illness was in terms of the consequences of his behavior for his family's well-being. (See Table 29).

Overall, the degree of societal threat that the behavior appeared to represent was the factor most used by people in arriving at an estimate of its seriousness: 55 per cent of the American public (who made up about two-thirds of those who discussed the bases which determined the seriousness of mental illness) cited the consequences or absence of consequences for others as a determining consideration, with 52 per cent calling some instance of mental illness serious because it posed this kind of social threat and 10 per cent calling some instance not

serious because of the absence of such a threat. Next most frequent as a factor determining the seriousness of mental illness was the presumed difficulty or ease with which it could be corrected, with 17 per cent citing such factors as incurability, irreversible brain damage or difficulty of treatment as proof of seriousness and 39 per cent dismissing its seriousness because of their belief that the illness could be rather easily cured by any one of a variety of methods. All told, about three-fifths of those who discussed the question of seriousness (46 per cent of the public) cited these treatment considerations. A third factor in the seriousness of mental illness was the presumed degree of urgency for action with respect to it, which often proved upon further inspection to be a simple restatement that the behavior was dangerous for others and should therefore be immediately brought under control or that it was not dangerous and nothing need be done about it. Thus 23 per cent cited the need for action as proof of the seriousness of the illness they were discussing, but only eight per cent referred to this sense of urgency entirely apart from the question of the social dangers of the behavior; similarly, 10 per cent cited the lack of urgent need for correction as proof of its lack of seriousness, either directly or by stressing the widespread, commonplace character of the behavior. A fourth factor in the seriousness of a mental illness was, quite explicitly, the degree to which the illness approximated psychosis: 13 per cent called some instance a serious mental illness because it was or could become psychosis or because of the presence of psychotic-like symptoms, particularly, a break with reality; and seven per cent denied the seriousness of one or another instance just because it was not psychosis or because extreme degrees of irrationality and inability to deal

with reality were not present. The fifth and final factor in the seriousness of mental illness was the degree to which personal suffering, either physical or emotional, was entailed: 17 per cent called a mental illness serious when it was impairing the individual's health or spoiling his life. Significantly enough, the question of personal suffering, unhappiness or lack of fullfillment was raised only indirectly, when the mental illness was regarded as not serious, where it was linked to the absence of social danger in some such comment as, "He's not hurting anyone but himself."

The considerations which entered into people's explanations of what made mental illness serious or not serious may, then, be summarized, from the detail in Tables 29-30, as:

Degree of societal threat	55%
Difficulty or ease of treatment	46
Urgency of need for action	30
Degree of approximation to psychosis	18
Degree of personal suffering	17
No classifiable reasons given	20
	187%

Aside from the last one, all of these factors combined harmoniously into the position that mental illness appeared serious to the American public to the degree that it approached their image of psychosis. In fact, when the two atypical cases--"Bill Williams" and "Bobby Grey"--are left out of account, the examples remaining constituted a unidemensional scale of mental illness, so that the degree to which an example was considered mental illness was, itself, an indication of the public's view of the severity of that disorder.[24] And, for the four examples which do represent

[24] See Chapter 4, p. 5.

this kind of continuum, the seriousness with which the public regarded it

was an almost exact counterpart of their views of its severity, so that violent psychosis was most serious and personality disorders, least serious:

	Proportion Saying Example Is Mentally-Ill	Proportion (of Those Saying Mental Illness) Saying It Is A Serious Mental Illness
"Frank Jones" (Paranoid)	75	71
"Betty Smith" (Simple Schizophrenic)	34	47
"George Brown" (Anxiety Neurotic).	18	34
"Mary White" (Compulsive-Phobic)	7	19
"Bill Williams" (Alcoholic)	29	73
"Bobby Grey" (Conduct Disturbance)	14	62

It can be said that the two examples of disturbed conduct do not fit into the same continuum of mental illness precisely because their seriousness was disproportionate to their severity. Or, more speculatively, they shared in the uncontrolled conduct toward others which led the public to take a serious view of violent psychosis, without having the more cognitive irrationality needed to qualify them as an illness of the same severity as psychosis.

Both the tendency to regard only psychosis as serious and the partial exception from this rule of behavior which had anti-social qualities are further confirmed by some additional data. With each of the hypothetical individuals for whom the comparison is possible, the people who thought the example was a psychotic were more likely to regard the person as seriously ill than were people who thought the very same behavior represented a non-psychotic mental illness. At the same

time, however, views of the seriousness of the example's mental illness were most affected by the diagnosis given it in the instance of a socially benign neurotic disorder like "George Brown's," where people who thought he was psychotic were almost twice as likely as people who did not to take him seriously. Diagnosis made the least difference in the alcoholism of "Bill Williams," where the difference, though consistent with the others, was not large enough to be statistically significant:[25]

[25]The examples of "Bobby Grey" and "Mary White" must be omitted because there were so few people who regarded them as psychotic. (See Table 15). The large group who did not indicate how they would classify the mental illness is, for the sake of simplicity, also omitted from each example.

	Proportion Saying It Is A Serious Mental Illness	
	People Who Said It Was Psychosis	People Who Said It Was Not Psychosis
"Frank Jones" (Paranoid)	78	62
"Betty Smith" (Simple Schizophrenic)	71	55
"Bill Williams" (Alcoholic)	79	72
"George Brown" (Anxiety Neurotic)	67	37

Because of the relatively small number of people who made differential diagnoses of the examples, the reasons why behavior presumed to be psychosis was regarded more seriously than behavior presumed to be non-psychotic mental illness can be examined directly only in the instance of "Frank Jones." For him, at least, it is clear that psychosis was regarded seriously primarily because of threat it posed, although the presence of violence in his behavior was sufficient reason to call it serious, even when he was considered non-psychotic; that is, 77 per cent of those who called his illness psychosis and serious cited his dangerousness for others, while 52 per cent of those who said he was non-psychotically but seriously mentally-ill did. Aside from the threat of

violence, however, people who viewed his presumed non-psychotic illness as serious were concerned with the possibility that his illness would develop into psychosis, especially, if nothing were done about it, with 45 per cent citing the likelihood of the illness becoming psychosis and 34 per cent, the concommitant urgency of doing something immediately as reason to take his behavior seriously. In contrast, 11 per cent of those who said it was psychosis cited this fact, itself, in proof of seriousness, and 18 per cent mentioned the urgency of controlling his behavior. In other words, there is here, again, the atypical seriousness of all behavior which has undesirable consequences for others, whatever the presumed severity of the illness; but, as just suggested in the preceding section, psychosis typified this threat, which, though couched in terms of direct physical danger, actually went far beyond it into a fear of the uncontrolled and uncontrollable. Insofar as non-psychotic illnesses did not include deleterious social consequences, there was nothing intrinsically serious about them; their seriousness derived only from the potentiality that they would develop into the seriousness of psychosis, a development which, as we have seen, was a widely-held expectation.

On the other hand, to the extent that "Frank Jones'" mental illness was not taken seriously, the major consideration was its amenability to treatment, irrespective of whether it was viewed as psychosis or some other mental illness. Thus, 84 and 82 per cent, respectively, cited possibilities of cure as their reason for viewing his illness as other than serious, so that psychosis emerged as more serious, in part, at least, because there was less overall optimism about its amenability to treatment. That is, references to the curability of the illness were

made, most frequently, by people who dismissed its seriousness, but were also added as qualifications to the views of those who thought it was serious. Within each of these groups, however, those who thought they were dealing with a non-psychotic mental illness were more likely to be hopeful about treatment:

		Proportion Referring to Relative Ease of Treating "Frank Jones"
Serious:	Psychosis	6
	Not psychosis	18
Not Serious:	Psychosis	33
	Not psychosis	37

It is noteworthy, moreover, that people who took a serious view of mental illness had in mind somewhat different forms of treatment than those who thought it not so serious. That is, people who were thinking in terms of professional treatment and, particularly, psychiatric treatment took a more serious view of the illness, consistently for each example, than people who believed it could be handled by self-discipline or lay advice. (See Table 48.) As a result, serious mental illness was most likely to require the services of a psychiatrist, while, with less serious mental illness, both self-help and the guidance of friends assumed more importance. If behavior is thought of as a continuum from normal to abnormal, then both the lesser emphasis on psychiatry and the increased emphasis on self-help in connection with mental illness that was not regarded as serious served to place it somewhere between serious mental illness and behavior that was not regarded as mental illness, as may be seen by comparing Table 48 with Table 43. While this patterning conforms to expectation, the increased emphasis on rational counseling from family or friends in connection with forms of mental illness not

classed as serious served to increase rather than decrease the contrast between it and non-mentally-ill behavior.

All of these results fit very well, however, with the major theme: mental illness appeared serious to the American public to the degree that it approached their images of psychosis and psychosis, itself, loomed as serious because it represented a threatening extreme of irrationality. With non-mentally-ill behavior, irrationality was seldom the nub of the difficulty, and neither psychiatric treatment nor friends' persuasion toward reasonableness was particularly appropriate. With serious mental illness--or psychosis--irrationality and lack of control did appear to be dominant, but in forms so extreme that the patient was incapable of being reasonable and so not amenable to rational persuasion, but better left to professionals in the techniques of dealing with irrationality. Between the two, however, stood the non-psychotic mental illnesses which were not serious--just as they were often not mental illnesses--because they represented unreasonable behavior on the part of persons who were presumed to be capable of rational behavior if they chose to. It was here, of course, that lay efforts to guide and persuade were particularly relevant and, it may be added, that professional psychotherapy also assumed this rationalistic cast.

Obviously, as the data themselves everywhere indicate, this is an idealized statement from which there was a good deal of empirical variation. Even for serious mental illness, psychiatry was not the majority solution, and lay approaches were frequently recommended. There is, also, some evidence in the case of "Frank Jones" that, although psychiatric treatment was thought of in connection with more serious rather than less serious mental illness, it was most typically

viewed as particularly appropriate for preventing mental illness from developing to the stage of psychosis. Thus, psychiatry was disproportionately recommended for the treatment of non-psychotic mental illness, at least in the case of "Frank Jones":

		Proportion of Those Recommending Treatment of "Frank Jones'" Mental Illness Who Mentioned Psychiatry
Serious:	Not Psychosis	53
	Psychosis	43
Not Serious:	Not Psychosis	40
	Psychosis	25

These data, which are confirmed in the other examples to the extent that the exceedingly unreliable data resulting from them can be regarded as additional confirmation, suggest at once a cleavage between psychotherapy and other forms of psychiatric treatment, with psychotherapy viewed as particularly relevant to individuals capable of being reasoned with and particularly urgent when their non-psychotic illness might otherwise develop into psychosis, while other forms of therapy, not dependent on reasonableness, were needed for psychotics. This distinction between forms of psychiatric treatment will be discussed further in Part III, and is cited here only because it again illustrates the seriousness of psychosis and the role played in its seriousness by the absence of rationality.

The Fate of Technical Concepts

In their discussion of the six individuals whose behavior was offered for interpretation, people sometimes employed a variety of concepts which had originated in technical discourse, as well as others of more homely origin. The exact terms used were preserved, both as a

rough index of relative public familiarity with these terms and as an opportunity to compare the way such concepts were popularly employed with their original meaning and usage. This question assumes some importance, on the one hand, because communication between the psychiatric field and the public requires a shared vocabulary and, on the other, because it is sometimes assumed that the introduction into popular discussion of technical terms free of undesirable emotional connotations will have the effect of modifying or removing the previous connotations of subjectmatters for which neutral terms of reference are popularized.

As was suggested at the beginning of this discussion of the meaning of mental illness, technical terms had not made much inroad into popular vocabulary, at least not to the extent that people used them spontaneously. Table 21 summarized the frequency with which a variety of most-used terms entered into people's discussions and indicated that, of the more technical terms, only "alcoholism" and the concept of "inferiority complex" were familiar terms of discourse for any appreciable number of people, while "habits," "nervousness" and the use of popular typologies were all more frequent than any of the semi-technical words.

The fact that the more technical vocabulary did not come spontaneously to most people, as they discussed emotional and personality problems, does not, of course, in itself, imply that people would not have recognized and unequivocally understood such words if they had been introduced into the discussion, but other studies--notably the one cited in Chapter 5--indicate that public recognition and understanding of the

vocabulary of the mental health field were similarly low.[26] Whereas,

[26] Washington Public Opinion Laboratory, op. cit.; especially Vocabulary Summary Tables 36-39, pp. 51-54.

in our study, three, two and one per cent, respectively, spontaneously used the words, "neurosis," "schizophrenia" or "psychosis," (or their adjectival forms) in their discussions, the Washington State study reports 36, 10 and 10 per cent who said, when they heard these words, that they were "very sure" of their meaning. And, in taking a guess at their meaning, at least so far as deciding whether they were references to diagnoses, causes, symptoms or treatment, 45, 34 and 32 per cent, respectively, correctly identified them as references to kinds of mental illness. There was, moreover, not too much understanding of the forms of mental illness denoted by these terms: for instance, only 48 per cent said "False" to the statement that "In general, neurosis is a severe mental disorder requiring hospitalization"; only 16 per cent disagreed with the statement that "Psychosis is a mild form of mental illness"; and only 35 per cent disagreed with the comment that "Schizophrenic persons seldom daydream." To round out this picture, 37, 51 and 11 per cent, respectively, agreed with each of these statements, while the remaining people simply said they didn't know.

Much the same kind of uncertainty can be shown for the far smaller groups of people who chose to use these diagnostic terms in our research, even though it might be expected that people who were familiar enough with the terms to volunteer them would have had a better understanding of their meaning than people who were not so conversant with them. Of these three, the small number of people who used the term "schizophrenia," were most accurate in their references:

91 per cent of them used the term to refer only to "Frank Jones," "Betty Smith" or both, and regarded the examples thus classified as mentally-ill; four per cent applied it to examples other than these two, but considered anyone they called schizophrenic mentally-ill; and five per cent applied it to the two more appropriate examples but did not consider that this term meant they were mentally-ill. With psychosis, exactly two-thirds (67 per cent) employed it as a term referring exclusively to mental illness and applicable only to syndromes of the "Frank Jones" or "Betty Smith" type, of the six presented; another 17 per cent limited the term's reference to mental illness, but extended it to syndromes like "Mary White's," "Bill Williams'," and "George Brown's"; 16 per cent used the term to refer to something other than mental illness. The word "neurosis" was used to refer solely to mental illness by 58 per cent of those who used it, but 43 per cent referred the term to "Frank Jones" or "Betty Smith," while only 15 per cent kept it exclusively for reference to syndromes other than these. Finally, the one popular term of diagnosis, "nervousness"--which was used by 26 per cent of the American public with reference to one or more of the examples in contrast to the small proportions using the more technical terms--was employed even more ambiguously: it was used by only one-third to refer unequivocally to mental illness, with 11 per cent extending it to the psychotic-like reactions of "Frank Jones" and "Betty Smith" and 22 per cent limiting it to the other syndromes. In sum, the way these words were used by the people who spontaneously mentioned them was:

	Schizophrenia	Psychosis	Neurosis	Nervousness
Exclusively mental illness				
"Appropriate" syndrome only[27] . . .	91%	67%	15%	22%
"Inappropriate" syndrome	4	17	43	11
Not exclusively mental illness				
"Appropriate" syndrome only	5	4	30	52
"Inappropriate" syndrome	-	12	12	15
	100%	100%	100%	100%

[27] "Frank Jones" and "Betty Smith" are regarded as the appropriate reference for schizophrenia and psychosis and the inappropriate reference for neurosis and nervousness.

Obviously, to the extent that they figured in popular usage, these technical terms and the popular euphemism of "nervousness" had been assimilated to the views of mental illness which preceded their introduction. That is, (1) the further the term is, in its technical meaning, from the popular stereotype of psychosis, the less likely the term was to be regarded as referring to mental illness; and (2) insofar as the one technical term, "neurosis" was referred to mental illness at all, it was used, three-fourths of the time, to refer to psychotic types of behavior. Nervousness, unlike the more technical terms, apparently entered popular discourse to supply an alternative to mental illness to which what might be technically thought of as non-psychotic syndromes could be assigned without categorizing them as mental illness. Once again, then, it is apparent that the popular tendency was to cut off the continuum of behavior that might be regarded as mental illness in a much narrower way than was technically done, so that the category popularly regarded as non-psychotic was, technically, almost limited to psychoses, while the technically-defined non-psychotic syndromes were almost entirely removed from the mental illness sphere. While

these points have been made before in other contexts, it is important to note that the initiation of the public into the meanings of technical terminology had, largely, produced a systematic redefinition in which the meanings of these terms rather than conceptions of mental illness were altered.[28]

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[28] Much the same sort of conclusion may be reached in connection with popular use of the diagnostic term, "alcoholism," which has been omitted here because it was relevant to "Bill Williams'" behavior and discussed fully there. While popularization of the term, "alcoholism," had carried along with it some tendency to call the behavior mental illness, it had done little to alter popular ideas of the nature of excessive drinking or their attitudes toward it.

Aside from these more purely diagnostic terms, there were also a number of terms, technical and otherwise, used to refer primarily to symptoms visible in the behavior of one or another example. Since most of these words were applicable only to a single example, the particular terms used were probably a function of the kinds of examples chosen for presentation to the public and will be dealt with here even more cursorily than diagnostic terms. (The details will be found in Tables 20 and 49.)

First of all, there were a series of terms used primarily to refer to "Frank Jones'" paranoid behavior, although none of them was used with very great frequency. Thus, his symptoms were variously referred to as hallucination, delusion, persecution complex or guilt complex. Since this was the one example generally regarded as mentally-ill, all of these terms were usually--though not exclusively--employed in a context of mental illness. They were, moreover, terms which tended to imply mental illness to their users: 95 per cent of those who applied any of these terms to "Frank Jones'" behavior said he was mentally-ill

as compared with 75 per cent of the entire public. Somewhat similar to these terms was the use of the word, obsession, to describe either "Frank Jones'" paranoid tendencies or "Mary White's" compulsive-phobic difficulties. This term, too, was used slightly more often in the context of mental illness than in other contexts, and people who used it were more likely to call the example to which they applied it mentally-ill, than people who did not.

The words inferiority complex and introversion were primarily intended as characterizations of "Betty Smith's" withdrawal. Of the technical terms taken over by the popular vocabulary, none was so frequently used and so assimilated to popular thinking as the idea of inferiority complex. Of the fifth of the American public who used the term, 60 per cent referred it to "Betty Smith"; 43 per cent, to "Frank Jones"; nine per cent, to "George Brown"; and still smaller proportions, to the other examples. Although the term was, thus, primarily applied to the two examples most likely to be perceived as mentally-ill, it was used, almost generically to refer to both mental illness and personalities that were not mentally-ill, with more frequent application to the latter than the former. Its use had, however, no bearing on the perception of mental illness, and people who viewed any example as suffering from an inferiority complex were neither more nor less likely than people who did not use the term to conclude that the example represented mental illness. Introversion, on the other hand, did relate to the perception of mental illness: 50 per cent of those who said "Betty" was introverted also called her mentally-ill, while, overall, 34 per cent had.

The terms, claustrophobia, compulsion, quirk, superstition, fear

complex, and, to a lesser extent, fixation, mania and obsession, were used primarily to refer to the compulsive or phobic features of "Mary White's" behavior. All of these terms, except obsession and mania, were, consequently, used primarily to refer to behavior that was not considered mental illness. Of these terms, people who thought some behavior was an instance of a superstition in action were less likely to perceive mental illness than people who didn't use the term, while people who saw a quirk, mania or obsession were more likely to, and use of the other terms had no fixed significance. Thus, to take "Mary White" as an example, four per cent of those who were discussing a superstition said she was mentally-ill, while 11 per cent of those who called it a quirk and 25 per cent of those who called it a mania or obsession did. The comparable figure is, of course, seven per cent among the entire population.

Alcoholism and habit were the two words which referred primarily to "Bill Williams." Both of these have been discussed in connection with him, and, as indicated there, description of behavior as a habit--for other examples, as for "Bill Williams"--was associated with not perceiving mental illness in that example. Use of alcoholism to describe him increased the likelihood of perceiving mental illness in "Bill Williams'" behavior, although both alcoholism and habit were more often used in a context of non-mental illness than mental illness. Kleptomania, the only one of these terms that applied primarily to the child, "Bobby Grey," also was more frequently used by people who did not regard him as mentally-ill than by people who did. Among its users, however, 44 per cent said he was mentally-ill as compared with an overall 14 per cent.

All of these terms can be summarized into three major groups. There were, first, words like habit and superstition, which had originated in popular rather than technical discourse. This popular vernacular was generally more frequently used when examples which were not usually perceived as mental illness were discussed and were more frequently used by the people who did not consider the example mentally-ill than by those who did.[29] Second, were a group of popu-

[29]It should be noted that quirk is an apparent exception to the last part of this statement, perhaps because of its implications of deviancy.

larized terms of technical origin, of which inferiority complex and nervousness are the only clear examples. These terms, like the strictly popular ones, generally arose in the context of discussing examples that were not usually regarded as mentally-ill, but were used indifferently in the sense that people who called the example mentally-ill were just as likely to use such terms in describing the individual as people who did not. Finally, there were a group of technical terms which were not fully assimilated into popular discourse and, aside from alcoholism, were rarely used--such terms as schizophrenia, hallucination, persecution complex, introversion, claustrophobia, kleptomania, obsession, etc. When these terms applied to "Frank Jones," they were used primarily to refer to mental illness, but when they were used to refer particularly to "Mary White" they seldom implied mental illness, so that limitation of use of any of these terms to refer exclusively to mental illness varied from 95 per cent of the users of schizophrenia to 13 per cent of the users of claustrophobia. All of these more technical words had one thing in common, however: whenever they were used, they connoted mental illness more frequently than chance expectation, given

the general level of perception of mental illness in the examples to which they were applied.

The conclusion from these data must necessarily be mixed. Certainly, there was relatively little familiarity with most of the technical concepts; rather frequently, as shown in Table 20, terms were applied to examples to which they could not technically refer; and often, the terms had been transferred to popular vocabulary without their concommitant status of terms referring to aspects of mental illness. In all these ways, technical conceptions were subordinated or assimilated to popular conceptions of mental illness without much influence on them. Yet, to the extent that technical terminology entered popular discourse, there was also some tendency to use them correctly and to associate them to some extent with mental illness.

Although the data themselves cannot demonstrate it conclusively, it seems likely that terminological changes succeeded most easily when only the more immediate denotations of the terms were involved, while their implications and connotations encountered more resistance. Thus, everyone who used the word, claustrophobia, knew it had to do with fear of closed spaces and applied it solely to "Mary White's" fear of elevators. Even though that fear need not represent claustrophobia, they knew what the word meant and applied it plausibly. But, 87 per cent of them did not feel that a claustrophobic person should be called mentally-ill, and, while this is a significant decrease from the 93 per cent of the public who did not classify "Mary White" as mentally-ill, it is not a very large one. It appears, therefore, that extreme conceptions of mental illness and, especially, the attitudes surrounding the topic and perpetuating such conceptions of it did, in large

measure, result in incorporation of the technical terms, even by the few people who did, without very much acceptance of their implications. In a brief comment on this point, Dr. Davidson has traced what he considers to be the futility of attempting to modify attitudes in the mental health or any other field through alterations of vocabulary, in terms of the persistent attempt to find a socially polite way of referring to facilities for elimination.[30] As he points out, socially-

[30] Henry A. Davidson, M.D. "Psychiatry and Euphemistic Delusion," The American Journal of Psychiatry, Vol. 110, No. 4, (Oct., 1953), pps. 310-312.

correct usage has gone from "back house" to "privy" to "water-closet" to "toilet" to "lavatory" to "bathroom" to "powder-room," but, he concludes, "Each new word rapidly acquired that precise shade of meaning that the phrase-makers were trying to avoid." One need not, perhaps, deny the slight positive achievements that changes in words have accomplished to accept, with Dr. Davidson, the conclusion that attitudes are more basic than terminology and constitute the logical starting point or that, if attitudes were modified, terminological difficulties would largely disappear.

CHAPTER 6

SOME SOCIAL FACTORS IN CONCEPTIONS OF MENTAL ILLNESS

Introduction

Up to this point, discussion has proceeded as if the American public were an undifferentiated whole or, at least, a whole differentiated only by differences of opinion over the conceptual content, logical definition and identification of concrete instances of mental illness. While this device simplified presentation, it must be remembered that the typical approaches to mental illness so far portrayed were more and less characteristic of various segments or social sub-divisions of the nation, just as these approaches were, themselves, influenced by the varieties of social and personal experiences epitomized by differential group membership.

The many such differentiating factors which might be singled out for attention can be grouped, roughly, into three classes. People had, first of all and most directly, differing degrees of exposure to and contact with either mental illness or information about mental illness. This kind of first- and second-hand familiarity with mental illness, together with associated differences in degree of interest in the subject or of concern with it as a social problem, can be expected to influence thinking about mental illness in a most immediate way. Secondly, however, there are a number of broader factors, which help to place people in society and, so, to determine in part the kinds of interests they will develop and the kinds of experiences they will have. Here, the two correlative facts of occupation and of formal education can be expected to have most to do with the amount and kind of concern with, interest in and knowledge about mental illness people acquire, although a host of other factors--like religious

instruction, military service, the dominant ideas of the time of people's intellectually-formative years, etc.--may have similarly determining effects. Finally, there are a number of other social characteristics of individuals which have little direct influence on shaping their conceptions of mental illness, but which are, themselves, associated with factors that are determining. While the relationship of such largely-fortuitous circumstances to people's conceptions of mental illness must be looked upon as descriptive rather than explanatory, these relationships are often of great practical value, just because they tend to involve highly external, easily discernible facts about people and are, therefore, easy to use as a basis for selection. Thus, while it may not explain anything to know how conceptions of mental illness differ between the North and South or between city and farm or between parents and non-parents or between Negroes and whites, etc., these descriptive differences do serve to locate in a convenient way the groups with whom, for example, mental health education programs might be most and least concerned.

It is, obviously, impossible within the confines of this report to deal exhaustively with all of the social factors which may be related to the way people thought about mental illness. The intent is, instead to analyze rather thoroughly the role of information about mental illness and of factors influencing the acquisition of information in shaping conceptions of mental illness and to indicate, briefly, largely descriptively, and in terms of only a few of the major social axes, those segments of the American public whose thinking about mental illness most and least approached the point-of-view of present-day psychiatry. It will become apparent, as discussion proceeds, that many interesting and significant relationships have been only hinted at or even glossed over, rather than developed in full.

Almost all of these, if pursued further, would, it is believed, only serve to indicate again and in a greater variety of ways the general point of this chapter: namely, the extensive interpenetration into thinking about mental illness of all of people's major orientations to life and the many pervasive and special experiences that have helped to shape these outlooks. While it is inevitable that the rather arbitrary selection and emphasis adopted will not correspond exactly to any single reader's interests and curiosities, following all of these leads in all of their ramifications would be an endless task, especially with the multitude of data available in this research. It is hoped that the material presented is both sufficient to substantiate the major points and sparse enough not to obscure them in a mass of detail. At the same time, some effort is made to suggest, especially to other researchers, the many possibilities of the data available from this study for exploring other, more specific or more special problems in the social determinants of popular thinking than are explicitly dealt with here.

Education and Information

Roughly nine-tenths of the American public indicated that they had received information about problems of mental health and mental illness in one way or another. The major information sources, to which about four-fifths reported access, were the mass media--newspapers, magazines, radio and movies.[1] (See Table 50.) About two-thirds of the public had obtained at least some of their information about mental illness by informal word of mouth, primarily by discussing such questions with their families or friends,

[1] The infrequency with which television was mentioned as a source of information about mental illness is, most probably, simply a reflection of the fact that these interviews were conducted before the major expansion of television.

secondarily through discussion of the subject with their family doctors, and less often, through knowing and talking with persons who had been mentally-ill or persons with special professional qualifications in the field of mental illness.[2] A final source of information about mental illness, mentioned

[2]The use of contacts with mentally-ill persons as a source of information about mental illness is, of course, not the same as knowing a mentally-ill person. Only 11 per cent of those who knew someone who was or had been mentally-ill cited this contact as a source of information. The effect of contacts with mental illness on conceptions of mental illness, quite apart from whether or not people considered them informative, is discussed more fully in a later section.

by two-fifths of the public was a type here called "class" media, ranging from attendance at lectures and discussions and the reading of books--novels and non-fiction--about mental illness and related subjects to formal educational courses in psychology, mental hygiene, child development and the like and to actual professional training in psychiatry or allied fields--medicine, nursing, psychology, etc.

This simple listing of the avenues down which people reported that information about mental health and mental illness had traveled to them does not, of course, adequately describe the state of public information. In the first place, it represents claimed exposure to information and tells us nothing about whether or not the information contained was attended to and absorbed into people's thinking. In addition, there is little or no indication of the kind and quality of information the persons citing a particular source were exposed to. That is to say, the topic of "mental health problems" is broad, and neither the particular facet of the problems that a person had in mind nor the technical competency of its treatment is suggested by naming the source alone.[3] While it seems likely that the "class" media communicated

[3]Initial versions of the interview schedule included questions aimed at determining the exact sources from which people had obtained information, so that the kind and quality of information people relied on could be more accurately assessed. Attempts to obtain more definite listings of sources--by means of such questions as "Which magazines were those?", "Which books were those?", "Which movies did you see?", "Which radio programs did you hear?"--were so uniformly unsuccessful in securing precise and reliable information that this goal was abandoned.

more accurate information, by and large, than the mass media, the range covered by any one source of information is so great that even this assumption is uncertain. Take, for example, a person who said he had obtained information about mental illness from the newspapers: he might have been referring to a story about a wanted criminal's previous hospitalization for mental illness, to an exposé of conditions in state mental hospitals, to psychologically-tinged or medical advice columns, to articles on child guidance, and so on. Similarly, radio coverage has ranged from serious attempts to discuss the nature of emotional problems, to news broadcasts about current conditions, to melodramas featuring psychiatrists as villains. But, on the "class" side, the books read or lectures attended, could equally well range from popular works of "self-help" psychology to the most technical, from an emphasis on the institutional side of psychiatry like Snakepit to an emphasis on psychotherapy like Wasteland. And, even more obviously, word-of-mouth information about mental illness might refer to anything from gossip about a friend's breakdown or comments on the day's news to serious discussions of psychiatric theory and practice.

Despite these ambiguities, the simple device of counting the number of different sources from which people said they had obtained information about mental illness does afford a rough measure both of the degree to which people had been interested in and attending to information about mental illness and of the amount of information they had.[4] It may, at first,

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[4]Repeated studies have demonstrated that exposure to available information does not generally take place in the absence of interest in the subjectmatter, and, where it does, the information usually is not retained or has little effect on attitudes. See, for example, Herbert H. Hyman and Paul B. Sheatsley, "Some Reasons Why Information Campaigns Fail," Public Opinion Quarterly, Vol. 11, No. 3 (Fall, 1947), reprinted in Daniel Katz, et al. (eds.), Public Opinion and Propaganda, New York: The Dryden Press, 1954; and Shirley A. Star and Helen MacGill Hughes, "Report on an Educational Campaign: The Cincinnati Plan for the United Nations," The American Journal of Sociology, Vol. 55, No. 4 (January, 1950).

appear that an information exposure score of this kind adds together highly unequal things as if they were equivalent, so that--to take the most extreme instance--the reading of even one newspaper story receives exactly as much weight in the total score as does professional training of several years' duration. There is, however, a kind of natural hierarchy among these sources that helps to compensate for this shortcoming. Thus, the person with professional training is likely to attend as well to what the mass media are saying about his specialty, to keep up with books about it and to discuss it, the net effect being that he acquires a higher total exposure score than others. As a result of this tendency, people who named any one of the "class" media as a source of information almost always named other types of sources as well--96 per cent mentioned mass media, 80 per cent mentioned informal, interpersonal channels--and had substantially higher informational exposure scores, on the average, than people whose sources did not include the class media: 5.5 as compared with 2.7. Consequently, the simple numerical count of sources used reflects not merely the number of sources but, generally, their type as well. Thus, class media was mentioned by eight per cent of those who named only one or two sources, but by 93 per cent of those naming six or more.

The significance of information is, simply, that the greater the amount of exposure a person reported the more likely it was that his conceptions of mental illness approached professional views. Thus, the proportion whose general discussions of mental illness had consistently included non-psychotic types of syndromes in mental illness increased from 17 per cent of those with no sources of information about mental illness to 47 per cent of those who had used more than eight sources:

Number of Information Sources Used	Proportion Whose General Usage of Mental Illness Consistently Included Non-Psychotic Syndromes
None	17
One	20
Two	24
Three	26
Four	30
Five	36
Six	37
Seven	34
Eight	40
Nine or more	47

Since the cogency of this general conception of the meaning of mental illness and its accompanying tendency to define mental illness as a deviant emotional response to the recognition of mental illness in concrete instances has already been emphasized, it is not surprising that the group with most exposure to information was also substantially more likely than people with lesser degrees of information to classify each of the six illustrative persons as mentally-ill. And, it may be noted, the number of information sources employed made the largest relative difference in classifying the instance of alcoholism, the one syndrome of the six which had been receiving a good deal of attention in popular media. (Table 51.)

Information about specific social problems cannot be divorced from persistent social differences among the American people, for it is generally the higher socio-economic groups, particularly people with college education, who indicate the most concern with broad social issues and who tend to be best informed about them. Mental illness was no exception to this rule, and it was, by and large, the more highly educated groups in the population who were most disposed to give conscious attention to it. As shown in Table 50, college graduates reported an average of 5.7 sources of information

about mental illness, as compared with an average of 3.6 sources for the adult population as a whole or of 2.2 sources for people whose education did not extend to graduation from grammar school. In broader terms, 60 per cent of those who were college graduates had obtained information from at least six sources, and this proportion declined steadily to only seven per cent of the least educated group in the population; conversely, only one per cent of the college graduates had no sources of information, and only 11 per cent were limited to two sources or fewer; in the lowest educational stratum, 23 per cent had no sources of information and 63 per cent relied on two or less.

This variation in attention given to mental illness was not merely a difference in amount, but in kind and quality as well. That is, while people of highest educational background were most likely to have used each of the possible information channels, they were particularly likely to mention disproportionately the class media--professional training, formal education, lectures and books. Thus, over three-fourths of the college graduates and two-thirds of those with some college education, short of completion, named at least one of these sources, while slightly over two-fifths of the people of high school background, but only a quarter of those with grammar school education did. The use of mass media showed a less marked decline with decreasing educational background, although attendance at movies dealing with mental illness problems and the reading of related magazine articles and even relevant newspaper stories declined more sharply than did radio. Although people of lower educational status were similarly less inclined to talk about the subject as well, to the extent that they did give mental illness any attention they were more dependent on word-of-mouth for their information than were people of more

education. "Talking with family and friends" was the single most frequently mentioned source of information about mental illness for people who had not graduated from grammar school; it fell to second place, following newspapers, for grammar school graduates; and it ranked below both newspapers and magazines in the high school and college groups. Among people who had at least one source of information, the proportion dependent entirely on these informal channels of interpersonal communication, through which they presumably heard at second-hand what others had obtained more directly from the mass or class media, rose from two per cent of the college graduates to 21 per cent of those with less than grammar school education.

Given this marked relationship between access to information about mental illness and general educational background, there were, as might be expected, consistent and large differences in approaches to mental illness among people of differing educational levels. As shown in Table 52, only one-third of the people who had not completed grammar school began their discussions of mental illness with references to non-psychotic syndromes, while almost two-thirds of the college graduates did. In everything they said generally about mental illness before discussing the six concrete examples of human behavior, 31 per cent of the lowest educational group described only psychotic syndromes, while 11 per cent of the college graduates' descriptions were similarly limited. College graduates were not merely more likely to describe non-psychotic syndromes in connection with mental illness, but were also more likely to adhere consistently to their inclusion within mental illness. Thus, half the college graduates who referred to them at all were consistent in their inclusion within mental illness of non-psychotic forms, while less than a third of the lowest educational group who referred to them were consistent about

including non-psychotic illnesses. As a result of both the greater awareness of non-psychotic mental illnesses and the greater consistency with which this usage was applied at the higher educational levels, the proportion whose usage consistently included non-psychotic forms of mental illness declined steadily from 44 per cent of the college graduates to only 20 per cent of the group with least formal education.

In keeping with these differences in general conceptions of the inclusiveness of mental illness, the proportions who recognized any one of the concrete examples as mentally-ill also tended to decline steadily with education. Among college graduates, for example, only five per cent concluded that none of the six was mentally-ill, while 24 per cent of the people who never finished grade school thought none was mentally-ill. Similarly, the average college graduate called 2.6 of the six hypothetical individuals mentally-ill; for the average person who attended college but did not graduate, the figure was 2.3; for high school graduates, 1.8; for people with some high school but not the full four years, 1.6; for grammar school graduates, 1.5; and for people with less than eight years of formal schooling, 1.5. Education made the greatest relative difference for instances like "Bill Williams'" alcoholism and "Bobby Grey's" delinquency, where college graduates were almost three times as likely to see mental illness as the lowest educational attainment group. The instance of alcoholism, in fact, presents the most dramatic differences, with over half the college graduates but less than a fifth of the grade school groups calling that behavior pattern mental illness. It may be noted that people with college backgrounds were always most likely to call each of the examples mentally-ill, but that, below the college level, educational differences usually narrowed, so that, with "George Brown's" chronic anxiety

and "Mary White's" compulsiveness, there were no differences between the perceptions of people with high school and grade school education.

These differences in viewpoint between the more and less educationally-advantaged segments of the American population were, of course, in part a function of corresponding differences in access to information specifically relating to mental health and mental illness. As Table 53 makes clear, the atypical college graduate who reported relatively few sources of information about mental illness was generally not as likely to subscribe to the conceptions of mental illness associated with his social group as was a person of less formal education but more specific exposure to mental health information. For instance, high school graduates with high exposure were consistently more likely than college graduates with low exposure to perceive each of the six concrete examples as mentally-ill, so that 17 per cent of the former as compared with 12 per cent of the latter were consistent in extending recognition of mental illness at least through the neurosis typified by "George Brown." Similarly, in general conceptions of mental illness, the more informed high school group either equalled or exceeded the less informed college group in spontaneously and consistently referring to non-psychotic syndromes in discussing mental illness and in classifying "nervous breakdowns" as mental illness.

At every educational level, from the lowest to the highest, people who had attended to more sources of information about mental illness were generally more likely than their formal educational equals with fewer sources of information to approach these conceptions of mental illness, the differences being quite consistent and, frequently, large. Nevertheless, within the portion of the public who reported most informational

opportunities, differences between educational strata remained substantial and, frequently, widened, the suggestion being that people with college education had derived either more or different information from the sources they used than other groups did from their sources.

It is possible to take into account, in a rough-and-ready fashion, some indication of either the saliency of the particular information people had seen to their conceptions about and perceptions of mental illness, or the effectiveness with which the information communicated by the source was absorbed into people's thinking, or, more probably, an amalgam of both. That is to say, however many sources of information people reported, these may be regarded as having dealt with aspects of mental health and mental illness other than the definitional elements being considered or as having failed to communicate their ideas successfully, unless contact with these sources eventuated in a general conception of mental illness which consistently included more than psychosis under that heading.

When this general usage is adopted as the criterion of information relevance and success as distinct from sheer information exposure, it becomes apparent that both aspects of information contributed to shaping conceptions of mental illness. Speaking generally, among people of the same educational background and the same amount of information exposure, those whose general usage included the non-psychotic were more likely to perceive mental illness in the six examples than people whose usage was not consistently non-psychotic; among people with the same amount of formal schooling and the same general conception of mental illness, those with more exposure to information were more likely to perceive mental illness than those with less exposure; and, finally, among people with the same usage and the same amount of exposure to information, those with

college education were more likely to call the examples mentally-ill than those with less formal education. Although Table 54 is rather complex, and, at times, based upon small numbers of cases, nevertheless, in 89 out of the 96 possible comparisons, people whose usage was consistently non-psychotic were more likely to perceive mental illness than were people of similar education and information exposure but different general conceptions of mental illness. Similarly, in 54 out of 64 possible comparisons, people with most exposure to information were more likely than people with similar education and general conceptions of mental illness but lesser degrees of contact with information sources to perceive mental illness; in 46 of the 64 comparisons the full pattern prevailed so that people with high information scores exceeded those with middle scores, who in turn exceeded those with low scores. In some contrast to this consistency with which differences of perception were associated with the amount and kind of information about mental illness people had attended to, among people of comparable information exposure and general usage those with college education had a higher percentage perceiving mental illness than any of the other educational strata in only 35 of the 48 comparisons possible; those with less than high school education were lowest in only 29.[5]

[5]These educational relationships are complicated by the fact that the concrete forms of mental illness represented by the six examples cannot be treated entirely as an entity. An examination of the details for each example suggests that there are variations which have to do with the nature of the particular example rather than mental illness generally. Thus, the fact that people of high school but no college education were, in four of six possible comparisons, least likely of the educational groups of similar informational status to perceive mental illness in "George Brown" and "Mary White"--both of whom suggested "white-collar" types of roughly the same social status as these respondents--suggests that this group may have been superimposing some defensiveness about themselves on the more general tendencies being discussed. As indicated in the introductory section of this chapter, this is merely one of the interesting byways which cannot be treated fully.

It is, thus, apparent that some of the implications of education have been isolated here, for the variations in perceptions within the group with college backgrounds were always greater than variations between people of different educational background, but similar informational experience. For example, the percentage who called an instance like "Betty Smith" mentally-ill varied, within the college group, all the way from 69 per cent of those with high exposure and consistent non-psychotic usage to 22 per cent of those with low exposure and without this usage. Within the most exposed and consistent group, however, people of college background were about twice as likely to call her mentally-ill as were people of less than high school education--69 per cent versus 34 per cent, and educational differences were generally less extreme than this at other informational levels. Although educational differences were, thus, less marked when their significance for the amount, quality or effectiveness of information about mental illness is taken into separate account, they were, especially in the best informed group, substantial enough to make it equally clear that higher education represented a good many more social and psychological differences than have been caught in the relatively crude information measures so far introduced.

Interest and Experience

Apart from these formal matters of the amount and kind of information possessed by people of differing education, there are a variety of more subtle factors which may, perhaps, be summed up as the intellectual climate in which people live. This is, of course, a broad and diffuse concept covering such things as the formal courses of study people had

pursued, the topics of conversation they found interesting, group agreements on values and on ways of interpreting human experience, and so on. Put most generally, it is concerned with people's dominant orientations to life and is, thus, in part, an expression of their place in the social order, reflecting the prevailing ideas of the time, place and circumstances of people's intellectually formative years. In less forbidding language, it is simply that, given the fact of a college education, there is still every reason to expect that the approaches to mental illness of a person trained in psychology will differ from those of a chemical engineer, although both of them may also have acquired, by virtue of their general college experience, some common viewpoints not shared with the non-college-educated population. At the same time, a person who learned his psychology in, say, 1900, when biological approaches were more influential, may well differ substantially in his conceptions of mental illness from one trained in recent years under the influence of dynamic psychologies. It was not possible, within the confines of this research, to treat this question of intellectual environment exhaustively, but some of its broader dimensions may be sketched out by means of such variables as occupation, age and familiarity with psychiatry.

Thus, to start with the most obvious considerations, when people of college education are divided into those whose current professional activities and training were defined by them as related to psychiatry and mental illness and those in other professions, non-professional occupations, and non-working status, it was the former group who were most informed about the mental health field and most likely to operate with broad and consistent conceptions of mental illness. Among the small group who reported that their professional work fell within the mental health field

broadly conceived, for example, 96 per cent reported high information exposure, with the average person making use of 7.6 information sources. With other persons of college background, only 46 per cent were highly exposed to information, with an average of 5.1 sources. Similarly, 64 per cent of those "related professionals" adhered to a general conception of mental illness which consistently included non-psychotic forms of mental illness; 40 per cent of the other college-educated people did.[6]

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[6] While the figures for "related professionals" may, at first, seem unexpectedly low, and, almost to contradict their supposed expertness, it is largely the result of the subjective way in which this group was defined. Lawyers, for example, could well feel and report that parts of their professional training and experience were directly related to problems of mental illness; yet, other research has indicated that, as a group, lawyers were not well informed about these problems. A study of doctors, lawyers, teachers and clergymen in the city of Louisville, conducted by Elmo Roper, concluded:

> "Lawyers are the most conservative and, from the mental hygienist's point of view, the least enlightened group. Lawyers are more likely to resort to repressive measures in dealing with juvenile delinquency and mental illness..., they show considerably less faith in psychiatry than the other professional groups, and they are not much better informed on local facilities for care of mental patients than the population as a whole....Neither their education nor their present contacts seem to be functioning adequately to keep them up-to-date on current trends."

(Julian L. Woodward, "Changing Ideas on Mental Health and Its Treatment," American Sociological Review, Vol. 16, No. 4 /August, 1951/, pp. 453-4.) It seems likely that, had "related professions" been objectively defined, rather than relying on self-definitions, differences would have been even more marked than those reported.

Even when this comparison is restricted to people of presumably equal and high exposure to information about mental illness, the proportions with this consistent general definition of mental illness were 67 per cent among "related professionals" and 43 per cent among others with college backgrounds. Correspondingly, the "related professionals" also carried

forward their general conceptions of mental illness to more frequent recognition of mental illness in the six examples. For them, an average of 3.5 of the six were mentally-ill; for others of the same general educational background, 2.4 were. Clearly, then, people who were even marginally within the field of psychiatry had differences in approach which went beyond their general educational background and the amount of information to which they attended.

In a broad way, these differences may be thought of as reflecting the extent to which people had become acquainted with and influenced by contemporary psychiatric theory. For the last ten years, at least, psychiatry or, more particularly, psychoanalysis has been a subject of considerable interest and acceptance in intellectual circles, while it has not become as familiar or acceptable in other environments. Thus, three-quarters of the American public admitted to having known someone who had been institutionalized for mental illness and people of every educational level were about as likely to have this first-hand acquaintance with institutional psychiatry.[7] (Table 55.) In contrast to this rather general

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[7] The very fact that admitted acquaintance with institutionalized mental patients increased slightly from the lower to the higher educational groups suggests that not everyone who knew such a person was willing to state this fact to the interviewer, since repeated studies have indicated that rates of commitment to mental hospitals increase in the opposite direction. Clark, for example, found that people in high income and prestige occupations were less likely to be hospitalized with psychosis than people from lower occupational groups. (Robert E. Clark, "Psychosis, Income and Occupational Prestige," American Journal of Sociology, Vol. 54 (1949). Using a concept of social class highly correlated with education, occupation, income and social prestige, Hollingshead and Redlich have found that treated cases of psychosis came disproportionately from the lowest social class. (August B. Hollingshead and Frederick C. Redlich, M.D., "Social Class and Psychiatric Disorders" in Interrelations between the Social Environment and Psychiatric Disorders: Proceedings of the 1952 Annual Conference of the Milbank Memorial Fund, New York: The Milbank Memorial Fund, 1953.) The possible significance for attitudes toward mental illness of the contrast between people's reports and actual incidence is discussed further in Chapter 8.

acquaintance with institutionalized patients, however, less than a quarter of the American public knew anyone who had ever consulted a psychiatrist in a non-institutional setting or visited a public clinic.[8] And, acquaint-

[8] Only three per cent of the public reported that they knew or had known persons who received treatment at mental hygiene or guidance clinics, while 21 per cent knew or had known persons who received treatment from a psychiatrist, outside a mental hospital. It is, of course, possible that the latter group included some who, without being aware of the fact, were actually referring to persons who had seen psychiatrists at clinics.

ance with non-institutionalized patients of psychiatrists was markedly concentrated in the upper educational groups: over half (51 per cent) of the college graduates knew such a person, while this figure declined to 36 per cent of those with some college short of graduation and continued to decline steadily to only 11 per cent of those who had never completed grammar school. These figures suggest the extent to which psychoanalysis or other forms of psychotherapy, together with the theories of personality development associated with them, were in fashion intellectually, in educated circles and are not so salient elsewhere. As Hollingshead and Redlich have reported, actual use of psychiatric services for treatment of neuroses and emotional disorders followed much the same pattern, with such patients coming, most disproportionately, from the college-educated, but not the extremely wealthy, socially prominent, segment of society.[9]

[9] The Hollingshead-Redlich article was cited in footnote 7.

It was, at least in part, conformity to this intellectual current in their social world that accounted for differences in approaches to mental illness between the educational classes. Thus, at every level of formal education, people who were personally familiar with anyone who had received psychiatric assistance with a presumably non-psychotic problem

were more generally knowledgeable about the field, as well, to an extent greater than this one additional possible source of information would alone imply. Among people with college degrees, for example, close to three-fourths (73 per cent) of those who knew non-institutionalized patients of psychiatrists reported at least six additional sources of information, exclusive of these contacts, as compared with 43 per cent of those who knew only institutionalized patients and 45 per cent of those who knew neither type. And in every educational group, the informational advantage of people with contacts with psychotherapy were comparably large:

Educational Attainment	Mean Number of Information Sources Other than Contacts with Psychiatric Patients Reported by Each Contact and Educational Attainment Group		
	Knew Non-Institutionalized Patient	Knew Institutionalized Patient Only	No Contacts Reported
College graduate or above	6.1	4.9	4.8
Some college	5.7	4.6	4.0
High school graduate	4.8	3.9	3.2
Some high school	4.5	3.5	2.9
Grammar school graduate	3.7	2.8	2.2
Less than grade school graduate .	3.1	2.1	1.7

It is, of course, also possible that, to some extent, the occurrence within one's own social circle of difficulties requiring psychiatric help stimulated interest in the general area and thereby encouraged the acquisition of information about it. Certainly the fact that similar contacts with institutionalized patients in the absence of familiarity with persons receiving extramural therapy were also associated with higher information exposure supports this view. At the same time, familiarity with non-institutionalized patients was accompanied by more exposure to information than were contacts with institutionalized patients, and differences in information exposure were

proportionately higher as between those knowing only institutionalized patients and those knowing extra-mural patients than between those with no contacts with the mentally-ill and those with contacts with institutionalized patients. It is, therefore, apparent that the converse was also true; that is, the general climate of opinion--the degree of interest in and acceptance of psychiatry--was, itself, in part responsible for these interconnections between formal education, higher levels of information, and greater acquaintance with psychiatric treatment, not to mention actual differentials in the use of psychiatric treatment, as well.

Accompanying this advantage with respect to amounts of information on the part of people familiar with psychiatric patients were also the differences that might be expected with respect to conceptions of mental illness. People whose friends or acquaintances had sought psychiatric therapy were consistently more likely to express the views which have previously been shown to be associated with higher education and greater information--that is, to think of mental illness in general terms which left room for more than psychotic reactions and to carry over this general usage into more frequent perception of mental illness in the behavior of the six examples. And, while the data are quite complex and need not be presented here in detail, even among people with the same educational background, with exposure to the same number of information sources, and with sufficiently salient and effective information to adhere consistently to a general usage which included the non-psychotic, those whose sources of information included first-hand contact with extra-mural patients were slightly but consistently more likely than those without direct contact to identify mental illness in the examples. By way of illustration, only, here are the comparative proportions who regarded "George Brown"--

the anxious, irritable man--as mentally-ill:

	College		High School Graduate		Less than High School Graduate
Consistent non-psychotic general usage					
High information exposure (6-9 sources)					
Knew non-institutionalized psychiatric patient	43	75	32	51	30
Did not	40	63	31	28	26
Middle or low information exposure (0-5 sources)					
Knew non-institutionalized psychiatric patient	36	58	23	23	23
Did not	30	35	22	21	21
Other than consistent non-psychotic general usage					
High information exposure (6-9 sources)					
Knew non-institutionalized psychiatric patient	25	61	18	18	18
Did not	17	42	13	15	16
Middle or low information exposure (0-5 sources)					
Knew non-institutionalized psychiatric patient	16	34	10	11	13
Did not	13	18	7	10	13

Of greater significance, perhaps, than these relatively small differentials in conceptions of mental illness, were the differences in basic approaches to human behavior that lay behind them. For, just as the intellectual current of interest in psychiatric theory was reflected in the college graduate's familiarity with persons who had been treated by psychiatrists, it was also apparent in a tendency on the part of those groups who had most familiarity with psychotherapy to adopt modes of explaining human behavior that originally derived from psychiatric doctrine. While there are other differences in the ways people went about explaining the behavior of the six hypothetical individuals, the largest and most striking are in the extent to which early relationships with parents--

psychodynamic determinants--were looked upon as shaping the example's current behavior.[10] People of college background, for example, were almost

[10] As before, this category of causation is singled out as most nearly--of the causal categories used in this study--approximating the views of modern dynamic psychology, although, of course, it must be regarded as a rough approximation in the sense that classification as using this line of causation need not imply acceptance of all or even most of the implications of technical psychodynamic theories.

twice as likely as those of least formal education to explain in these terms one or more of the individuals considered: over three-quarters of the former but 40 per cent of the latter group sometimes turned to psychodynamics in explaining human behavior.[11] Similarly, 72 per cent of those

[11] A minor part of this difference is attributable to the fact that the number of examples discussed causally increased somewhat with increasing educational background, so that the better educated had more opportunities than the less educated to mention any particular cause. When this type of comparison is restricted to people who causally discussed the same number of examples, however, differences of almost the same order remain. For instance, among people who explained exactly three of the six examples, 65 per cent of the college graduates and 28 per cent of those who never finished grammar school mentioned psychodynamics for at least one of the three examples.

most exposed to sources of information about mental health and mental illness sometimes spoke of the psychodynamic development of an example, as compared with 46 per cent of those least exposed; or, again, 71 per cent of those who knew a person in psychotherapy, but 55 per cent of those who did not, made use of psychodynamic interpretations. When all three of these factors are considered simultaneously, 84 per cent of the people who may be regarded as "most involved" in the current movement of intellectual interest in psychiatry--that is, people with some college education, attention to a large number of information sources and contacts with persons receiving extra-mural psychiatric treatment--employed psychodynamic explanations, as compared with 40 per cent of those "least involved"

--people with less than high school education, few sources of information and no reported contacts with psychiatric patients. (Table 56.) It may be added that, as with the differentials in perceptions of mental illness just presented, all of these factors of orientation and outlook, while themselves interrelated, nevertheless each made an independent contribution to the tendency to think in terms of psychodynamics. That is, for example, among people with the same amount of formal education and information exposure, those whose acquaintance included recipients of psychotherapy were more likely to use psychodynamics than those who did not.

The psychodynamic approach was not only more wide-spread among those parts of the American population that roughly corresponded to the social circles most influenced by psychiatric thinking, but it was also more often applied by them, systematically, as a general scheme for interpreting all human behavior. For instance, among only those people who made use of psychodynamics at all and who explained three or more of the six examples, the proportions who used the same general psychodynamic approach to at least half of the examples they discussed were:

College graduate and above	39%
Some college	36
High school graduate	26
Some high school	22
Grammar school graduate	14
Less than grammar school graduate . . .	14

Or, the more systematic adherence to psychodynamic reasoning on the part of the people "most involved" with psychiatry can be seen, in a more general way, from the fact that group differences in the proportion of all examples explained whose explanation entailed psychodynamic causation are always more marked than group differences in the proportions using this causal explanation at all. (Table 56.) So, while college graduates

were 1.9 times as likely as the least educated group to use psychodynamics, they used such explanations 2.4 times as frequently in the examples they explained; the comparable ratios of "users" and "uses" between the most and least informed are 1.6 and 1.8; between those familiar with extra-institutional psychiatry and those with no contacts with psychiatry, 1.3 and 1.5; and, summarily, between the most and least "involved," 2.1 and 2.5.

Implicit in the more wide-spread and, particularly, the more systematic reliance on psychodynamic explanations by the more psychiatrically-oriented sub-groups was the fact that these same groups tended more than other groups to employ psychodynamic reasoning as a general interpretive scheme equally applicable to both sick and healthy personality development. When they did not employ it in this generic fashion, they tended to treat psychodynamics as a theory particularly adapted to the explanation of abnormal personality manifestations, in some contrast to those groups who were least involved in psychiatrically-influenced currents of thought, who tended strongly to restrict psychodynamic accounts to instances of behavior which they regarded as not mentally-ill.[12] To illustrate this tendency with only one of the variables affecting participation in psychiatric modes of thought, the contexts in which the various educational classes advanced psychodynamic explanations were:

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[12]These relationships are in part, of course, an artifactual result of the fact that the more educated groups both used psychodynamic explanations more frequently and classed more of the examples as mentally-ill. That is to say, if a person gave a psychodynamic explanation of only one example, he could hardly have employed that interpretation both in the context of mental illness and in some other context. Similarly, for more frequent use of psychodynamic causation, the closer a person approached to classing half the examples as mentally-ill and half as something else, the more likely it was that, by chance alone, psychodynamics would be used in both contexts. The association which exists goes beyond that which would result merely from these mechanical considerations, however, as

can be indicated in other ways. For example, the most involved explained a larger proportion of the examples they classed as mental illness by psychodynamics as compared with the proportion of non-mentally-ill examples to which they applied psychodynamics, while the reverse was true among the least involved, where the proportion of examples classified as mentally-ill explained by psychodynamics was appreciably smaller than the proportion of non-mentally-ill examples so explained. Thus, the proportions of all examples classed in a given way and explained in any fashion which were explained by psychodynamics by groups of different degrees of involvement were:

	Proportion of Examples Explained by Psychodynamics among Examples Classed as:	
	Mental Illness	All Other
Highest involvement	44%	37%
Intermediate involvement	23	24
Lowest involvement	8	14

It is apparent that the most involved explained non-mentally-ill examples by psychodynamics about two and a half times as frequently as the least involved, but they explained mentally-ill examples in this way five and a half times as frequently. The steeper decline in the use of psychodynamics in the context of mental illness as compared with the decline in its use in other contexts, itself confirms the statements made in text.

	Used Psychodynamics for Examples Classed As:		
	Mental Illness Only	Both Mental Illness and Other	Other Than Mental Illness Only
College graduate and above	33%	26%	41%=100%
Some college	22	28	50
High school graduate	18	21	61
Some high school	16	18	66
Grammar school graduate	15	12	73
Less than grammar school graduate. .	11	10	79

Much the same kind of tendency can be shown with each of the other variables defining involvement, or, to take them all at once, among the users of psychodynamics 33 per cent of the most psychiatrically involved applied this explanation to examples typifying for them both mental illness and other personality categories as compared with six per cent of the least involved; psychodynamics were applied only to mental illness by 30 per cent of the most involved and 15 per cent of the least involved; conversely, psychodynamics were applicable only to the development of non-mentally-ill

examples for 37 per cent of the most involved users of psychodynamic logic, but 79 per cent of the least involved.

What is apparent, then, is that the groups most in touch with contemporary psychiatric thinking were not only more likely to take over some of its major elements of personality interpretation, but were also more likely, when they did adopt these theories, to acquire more of their substance and implications, as well. This interpretation is still further confirmed by group differences in ways of handling problematic behavior. It was, once again, primarily the groups most subject to psychiatric influences--the college educated, the highly informed, the associates of people receiving psychotherapy--who thought of professional psychiatric care as the appropriate means of modifying the behavior of people like those used as examples. Among people who made any kind of recommendation at all, 30 per cent of the college graduates proposed psychiatric treatment for at least one example, as compared with seven per cent of the lowest educational group, and differences associated with information and contact were comparably large. (See Table 57.) In sum, those most involved with psychiatry were almost nine times as likely to recommend psychiatric care as were those least involved.

The sophisticates' greater reliance on psychiatry was not to be understood merely as a greater likelihood of calling behavior mental illness, coupled with a recognition that psychiatry was the medical specialty that dealt with mental illness. On the contrary, they were far more likely than were the less-educated, less informed and less knowledgeable to recommend psychiatry both for behavior they did not consider mental illness and for behavior they did so classify. For instance, 55 per cent of the "highly involved" and 21 per cent of the "least involved" recommended psychiatry for one or more of the examples they regarded as mentally-ill

and made some action suggestions for, while 14 per cent of the former and only one per cent of the latter suggested psychiatry for any non-mentally-ill examples for whom they made action suggestions.

These data, of course, underline the greater awareness of and reliance on psychiatry on the part of people who were closer to it and more informed about it, but more is involved than this simple tautology expresses. For, the entire pattern of action recommendations, taken as a whole, suggests the beginnings, if not the partial accomplishment of, the substitution of a psychological for a moral approach to human behavior, among this extreme of the American population. In addition to their stress on psychiatry, itself, the segment of the population most in tune with psychiatric thinking also gave disproportionate emphasis to lay psychological measures, particularly as a method of coping with non-mentally-ill behavior: 32 per cent of the "most involved" and 20 per cent of the "least involved" approached at least one non-mentally-ill example in these terms. Since this category of lay counsel and rational persuasion or discussion was not notably different from people's conceptions of professional psychotherapy, both of these action suggestions appear to represent a shift in the direction of the psychological management of problematic behavior, as compared with the solutions favored by other sections of the American public. In contrast to the psychological emphasis of the most psychiatrically-oriented, the other extreme of the population disproportionately proposed self-help, with its immediate implications of assessing moral responsibility and assigning blame, both for behavior they considered mental illness and, more markedly, for behavior they regarded as problematic in some other sense. Illustratively, 23 per cent of the college graduates but 39 per cent of the least educated who made treatment proposals suggested self-help for instances of mental

illness; 40 per cent of the former and 70 per cent of the latter made comparable action suggestions for instances not regarded as mental illness. To the extent that psychotherapy--whether administered by professionals or by amateurs--was regarded as an essentially rational process of advice and exhortation, moral assumptions about the individual's responsibility for accepting and applying good advice necessarily flowed from his presumed ability to benefit from it. Nevertheless, in comparison with the direct insistence on the individual's ability and duty to help himself entailed in the self-help school of thought, the psychotherapeutic emphasis appears as a change in the direction of subordinating considerations of moral responsibility to the immediate need of the individual for assistance with his psychological problems.

The Limits of Educational Influence

All of the data so far adduced point only to the conclusion that formal education--with its social-psychological implications of greater awareness of, sensitivity to, information about and interest in contemporary intellectual trends and its socio-economic implications of greater opportunity to pursue these interests--was the major social influence shaping popular conceptions of mental illness. At the same time, however, the data themselves also suggest--if only by the less than all-or-none quality of the relationships--that attendance at college did not inevitably mean that people, by that very fact, acquired either an interest in or the viewpoints of contemporary psychiatry. Some attempt has already been made to document the most patent of the variable influences making college education a fact whose meaning is not completely constant from one individual to another: namely, that the course of study in college (as reflected in subsequent career activities) increased or modified the extent to which college

education was a psychiatrically-educational experience. Just as obviously, there are a great many idiosyncratic variations, which research of this kind must necessarily gloss over--the particular college attended; an unusually influential teacher; one's college intimates, prior intellectual influences and present personality. All of these and, no doubt, many more unmentioned make college an experience whose meaning for and influence on the individual cannot be completely inferred from or indicated by the fact that he went to college.

Apart from these more unique aspects, which can only be mentioned here as additional, unexamined factors tending to diversify the general influence of education on conceptions of mental illness, there were also some more generic factors operating to make the views of a given educational class a good deal less than uniform. Among these is the fact that psychiatry--particularly as a body of psychological theory applied in psychoanalysis and other forms of psychotherapy--has been, up to now, a largely urban phenomenon. In 1953, almost three-fourths of the psychiatrists with any private practice were located in cities of over 100,000 population and over half in just ten of the largest cities--New York, Chicago, Philadelphia, Los Angeles, Boston, Washington, San Francisco, Detroit, Baltimore and Cleveland. And the situation with respect to qualified psychoanalysts was even more extreme: four-fifths of them being located in seven large cities, with close to a fifth in New York City, alone.[13]

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[13] Daniel Blain, M. D., "Private Practice of Psychiatry," Annals of the American Academy of Political and Social Science, Volume 286 (March, 1953).

While sheer acquaintance with the patients of psychiatrists was not quite as closely bound to the distribution of psychiatrists as actual use of psychiatric services would necessarily be, the fact remains, as suggested

by Table 61, that it was the people living in the largest metropolitan centers and next largest cities who were most likely to be in touch with persons in psychotherapy. People's general social class, as indexed by their formal education, remained the primary determinant of the extent to which their circle of acquaintances included psychiatric patients, but, within each educational class, urban dwellers were consistently more likely to be in touch with extra-mural psychiatry:

	Proportion knowing a non-institutionalized psychiatric patient
College-educated: urban (over 50,000) . .	46
non-urban (under 50,000)	37
High school-educated: urban	27
non-urban	21
Grammar school-educated: urban	16
non-urban	11

The role of the urban environment in facilitating contacts with psychotherapy or with its recipients is the more striking because it runs counter to the greater impersonality and anonymity of urban life. In city life, people's social circles are sufficiently narrowly defined that, despite the fact that commitment rates from large cities are substantially higher than those from more rural areas,[14] city dwellers were actually less

[14] Weinberg cites urban rates for commitment of schizophrenics 1.92 times as high as rural rates and refers to a study which found that, in urban settings, these rates increased as the size of the city increased. See S. Kirson Weinberg, Society and Personality Disorders. New York: Prentice-Hall, Inc., 1952, pp. 160-161.

likely than residents of smaller places--towns, villages and farms--to know anyone who had been institutionalized for mental illness, and even the urban group most likely to have such contacts ranked below any of the non-urban groups:

		Proportion knowing an institutionalized patient
Non-Urban (under 50,000):	College-educated	82
	High school-educated . .	80
	Grammar school-educated.	79
Urban (over 50,000):	College-educated	73
	High school-educated . .	70
	Grammar school-educated	65

It is, here, rather apparent that the more intimate, personal life of smaller towns brought the illness of any one person to the attention of many more people than would have been aware of it in an urban setting. So, if, as seems likely, the same small-town familiarity extended to people who sought psychiatric assistance, then it is understandable why the rural-urban differences in familiarity with out-patient psychiatry were relatively small. So far as first-hand familiarity goes, the actual preponderance of psychiatric patients in urban areas was somewhat balanced by the greater amount of notice given an individual's actions in smaller places. And, at the same time, other influences deriving from social mobility--like contacts with psychiatry while attending college, migration from urban to rural areas or vice versa, contacts with people living in other places, and military service[15]--served to reduce still more the effect of the current environment.

[15] World War II veterans, in comparison with other men of the same age and education, were somewhat more likely to have known someone treated by a psychiatrist--30 per cent as compared with 24 per cent, just as they reported somewhat more sources of information about mental illness--4.2 as against 3.6.

Nevertheless, the residual urban advantage in contacts with psychiatry, together with the slightly higher average education and slightly greater exposure to information of urban dwellers, made for an urban viewpoint on human behavior which inclined somewhat more than non-urban approaches to

psychodynamic interpretations and to psychological rather than moral correction. (See Tables 61-64.) At the same time, conceptions of mental illness did not vary markedly between urban and rural dwellers, primarily because it was the college-educated group whose thinking was most likely to reflect the influence of contacts with psychiatry, and this group was a small minority both in cities and in less urban areas.

If popular adoption of psychiatric points of view toward human behavior, generally, or mental illness, particularly, appears to have been primarily a movement of thought centered among urban intellectuals, it must not be overlooked that intellectual developments of this kind have a time as well as a place. It is quite consistent with modern intellectual history that people whose formal education antedated 1910--that is, roughly, people who at the time of this research were in their sixties or older and those in their fifties who had not continued their education beyond grammar school--were neither as familiar with nor as influenced by psychiatric thinking. As shown in Table 61, these older age groups were a good deal less likely to know anyone who had received non-institutional psychiatric care, even though, in the sheer course of having lived longer, they were more likely to have encountered someone who had required institutionalization for mental illness. Although these age differences in familiarity with extra-mural psychiatry presented in Table 61 in part reflect the lower average educational attainment of older people, the conclusion remains the same when the comparisons between older and younger people's acquaintance with psychiatric patients are restricted to roughly equivalent educational groups. Of people with some college education, 44 per cent of those under sixty years of age and 25 per cent of those sixty and over knew someone who had been treated by a psychiatrist outside an

institution; among those whose education stopped with high school, 27 per cent of the younger group and 16 per cent of the older group had this personal familiarity; among those who had only grammar school education, 15 per cent of those under fifty and 12 per cent of those fifty and over had first-hand contacts with psychotherapy.

The fact that older people were less in touch with psychiatry than younger people of similar background had its implications for the way older and younger people thought about mental illness. For one thing, the older segment of the population was also less interested in the general area of mental illness and mental health or, at least, attended to fewer sources of information about it, mean information-source scores being:[16]

[16] It is, of course, also possible that these differences represent a decrease in the amount of attention people gave to broader social questions like mental illness, as they grew older, rather than the persistence of a life-long pattern of interest and attention.

College-educated:	Under 60	5.3
	60 and over . .	4.2
High school-educated:	Under 60 . .	3.9
	60 and over	3.2
Grammar school-educated:	Under 60	2.8
	60 and over	2.1

Quite consistent with either their lower informational levels or their lack of first-hand contact with psychotherapy, the older age groups of the American population were, at every educational level, consistently inclined toward explanations of human behavior which depended on organic processes or innate personality factors. They were, at the same time, somewhat less inclined than younger people to explain human behavior either in terms of conditioning or, within the college group at least, in terms of psychodynamic development. (Table 59.)

An explanation of these differences must be somewhat speculative, but, if one looks at the history of psychological theories of behavior,

it is clear that organic and instinct theories were succeeded, in the '20's, by Watsonian behaviorism, which has, in turn, been largely displaced more recently by dynamic psychologies. In much the same pattern of succession, older people were more familiar with the organic and instinct doctrines that were current in their youth and adhered to them much more frequently than did younger people, from whose main period of intellectual development these theories were quite remote.[17] The conditioning approach roughly represents the next period of psychological thinking, although it has only the loosest connections with strict behaviorism. As the dominant mode of thinking about human behavior of the last generation or two, it was more frequently used by the younger groups, part of whose contemporary intellectual environment it was. Nevertheless, the viewpoint was so dominant and so congenial to the American temperament that older people had also absorbed this way of thinking, though they did so less often than people for whom conditioning was the originally-accepted way of looking at behavior. Psychodynamics, however, represents the newest approach to human behavior and, as with most intellectual revolutions, its influence has been felt primarily in intellectual or, at least, college-educated circles. For more

[17] Once again, these comments must be qualified by the possibility that the thinking of the older groups has changed through time and actually reflects their present age rather than the time when their ideas were first formulated. That is, for instance, it is possible that, as people grow older, their attention is turned more toward organic and physical determinants of behavior by their awareness of and concern with the deteriorative processes operating within themselves. It is not, however, so easy to formulate a plausible explanation of why people would come to place greater emphasis on the innateness of personality as they, themselves, aged, unless it be assumed that this tendency represents an increasing fatalism about the modifiability of human behavior. Since neither the interpretation in terms of the influence of the prevailing intellectual climate advanced in text nor this interpretation in terms of the influence of the aging process is definitively established by the research, the reader must decide for himself which interpretation seems more likely.

recently college-educated people, psychodynamics represented a quite conventional, accepted part of the intellectual climate and it was, consequently, a viewpoint a good deal more frequent among them than among people who had attended college at a different point in intellectual history. Beyond the college group, psychodynamic theories have not yet been so influential, and they were adopted, to the extent that they were, about equally by all age groups, presumably because psychodynamic thinking was equally foreign to the formative intellectual climates of both the younger and older person with no college background. In this connection, it may also be noted that, among younger people, the older, organic and instinct theories of human behavior were, generally, most current in the least-educated group, a pattern which suggests again the more rapid turn-over of ideas in educated circles and the slower rate at which new ideas reached the less educated to displace older modes of thought.

Accompanying these differences in the interpretations of human behavior advanced by younger and older people were corresponding differences in the means favored to modify it. Younger people, particularly at the higher educational levels, were more likely to suggest psychiatry as a way of dealing with behavior they called mental illness; older people were more likely to take a more directly moral approach and recommend self-help. (Table 60.) The emphasis on self-reliance in correcting individual behavior also ran through older people's discussions of examples they considered problematic in some sense other than mental illness.

Interestingly enough, differences in conceptions of mental illness between younger and older people followed somewhat the same pattern as the use of psychodynamic interpretations, or reliance on psychiatry as a corrective measure, with younger college-educated people more likely than

older ones to express those views of mental illness associated with knowledgeability--that is, to adhere spontaneously and consistently to a usage of the term mental-illness which equated it with more than psychosis and to perceive mental illness in the behavior of the six examples. (Table 58.) At lower educational levels, however, differences between age groups in general conceptions of mental illness were negligible or non-existent, while older people were actually more likely to perceive mental illness in the concrete examples than were their younger educational counterparts.[18]

[18]This last result is, without doubt, an exception to the education-information-experience determinants of conceptions of mental illness that cannot be fully explained by the data. It is possible that the longer lives of older people, alone, gave them a broader familiarity with human personality and its aberrations than measures of specific information about and experience with mental illness could reflect, so that, at the lower educational levels, especially, their wider general experience more than compensated for their apparent lack of information and contact.

In the large, however, there again appears the suggestion that the newer conceptions of mental illness--like the newer approaches to human behavior, generally--have had most impact among those whose college educations roughly corresponded in time with the technical dominance of the same ideas. They were, again, less influential among those whose college educations predated the period of modern psychiatry and still less operative among groups who were never exposed to the intellectual atmosphere of colleges and universities.

There are, of course, still other factors, operating independently of the influence of formal education on participation in the popularization of psychiatry, which tend to make such social class differences in interest and outlook less extreme than they might otherwise be. One familiar instance, already referred to, was the fact of widespread military service, which brought men of every educational class into closer contact than they

would most probably have experienced in the course of civilian life with psychiatrists, with men who broke down under stress, and with the standard psychiatric categories of diagnosis used for discharge from service.

Of a somewhat different order, but having the same effect of tending to reduce differences between educational groups are the facts of sex and parenthood. Both men and women were substantially similar in formal education, information about and contacts with mental illness, and their general conceptions and concrete perceptions of mental illness did not particularly deviate. (Tables 61 and 62.) Nevertheless, perhaps because of the social definition of sex roles, in which primary responsibility for child-rearing is assigned to women, women were, at every educational level, more likely than men to think of human behavior psychodynamically and to think of its correction in terms of psychiatry. At the same time, both men and women who belonged to the group of younger parents--that is, parents whose children were under eighteen years of age--were more likely than either older parents or non-parents to think of personality as a product of early relations with parents. Since only the residual effects of these tendencies are apparent in Tables 63 and 64, here are the proportions within the relevant sub-groups who used the logic of psychodynamics in discussing causation in human behavior:

	Men	Women
College-educated		
Parents		
Children under eighteen only	77	81
Some children over eighteen	69	79
Non-parents	74	78
Not college-educated		
Parents		
Children under eighteen only	57	64
Some children over eighteen	45	54
Non-parents	50	61

As is evident here, partly as a result of their age, but partly because of their interest in and responsibility for the raising of children, women generally and young parents, especially, acquired more knowledge of modern psychiatric viewpoints on child-rearing than would have been expected simply from their formal education.

Clearly, a variety of social experiences like occupational interests, urban impersonality, the "Zeitgeist," military service, parenthood (and many others that will occur to each reader as inexplicable omissions) cut across both to limit and to modify the determining influence of formal education on the orientations and interests of the social sub-divisions of the American population. In posing the issue in this way, however, there is a danger that the influence of education, itself--or, more strictly, the influence of the complex of social and social-psychological characteristics which education loosely represents--will be overemphasized. In one way, the differences in outlook that have been presented between younger, urban, highly-educated, informed, knowledgeable people in the mainstream of the spread of psychiatric ideas and their opposites were large, indeed. In another sense, however, even the most extreme group that can be singled out for attention was not exactly saturated with psychiatric viewpoints on human behavior, and it is this fact which points to the broad cultural similarities in the thinking of sub-groups of the American population, regardless of differences in degree among them.

It is, for example, not enough to say that the most involved group of the American population was three times as likely as the least involved to define mental illness in a way which consistently applied the concept to more than psychotic forms of illness. Large as this difference is, it must be added that, at either extreme, this approach to mental illness

represented a minority viewpoint--48 per cent versus 16 per cent. Or, similarly, if the definition of highest involvement is made even more extreme by adding to the criteria of college education, high information exposure and contact with non-psychotic psychiatric patients the requirement that these experiences must also have eventuated in a general conception of mental illness consistently including non-psychotic forms of mental illness, it can also be said that the most extremely psychiatrically-informed group was roughly three times as likely as the opposite extreme to classify the six examples as mentally-ill:

	Mean Number of Examples Classed as Mentally-Ill
Highest involvement: consistent non-psychotic usage. .	3.4
other usage.	2.2
Intermediate involvement: consistent non-psychotic usage. .	2.2
other usage.	1.6
Lowest involvement: consistent non-psychotic usage. . .	1.6
other usage.	1.1

What this difference means, however, is that 37 per cent of the first group and eight per cent of the last one perceived mental illness in the concrete instances of both "Frank Jones," "Betty Smith" and "George Brown"; that is, in practice, only minorities of all sub-groups of the population extended their perceptions of mental illness to include behavior not suggestive of psychosis. It makes a difference, certainly, that one per cent, at one extreme, and 45 per cent, at the other, perceived mental illness in neither the neurotic-like behavior of "George Brown" and "Mary White" nor the psychotic-like reactions of "Frank Jones" and "Betty Smith." And it is likewise significant that recommendations of psychiatric assistance for any of these examples decreased steadily from 42 per cent of the most

involved with consistent non-psychotic usage to four per cent of the least involved who did not have consistent non-psychotic usage, while suggestions for self-help rose from 34 per cent to 68 per cent of these same groups. In all of the instances cited differences of such large order resulted only because an upper two per cent of the American population is being compared with a lowest six per cent. The thinking of the great bulk of the American people lay somewhere between these two extremes and, generally, closer to the lower extreme than to the "psychiatric elite." Even so, the views of the elite group were neither unanimous in assimilation of the more psychiatric positions nor departures, except in degree, from the more general ways of looking at human behavior.

The basic clue to the underlying cultural similarities in thinking that operated as the ultimate limits to variations in conceptual systems between sub-classes of the population can be found in the kinds of logical considerations to which people turned in discussing mental illness. Given the relatively wide differences that variations in information and education implied both for symptomatic, descriptive definitions and for concrete perceptions of mental illness, it is rather remarkable that the non-descriptive criteria used to define mental illness--definitions of mental illness, it will be recalled, as either an organic brain disease, a disorder with no physical basis, a disorder with no causal relation to reality, a character weakness, or an involuntary loss of control--varied rather little from group to group. (Tables 51-54.) Although the vast majority of every subgroup of the American population turned to one or another of these non-descriptive criteria in attempting to define mental illness in a way that would explain why a particular example should or should not be included within the category, there were two opposite tendencies which, if not

outstanding, are, nevertheless, suggestive.

The general tendency was that better-educated, more informed people were, if anything, more likely to call upon one or another of these cultural postulates about the causes and nature of mental illness, and, as a result, to become involved in more internal self-contradiction and inconsistency than people with less education and information. For example, among people whose formal knowledge and exposure to information had not eventuated in a general conception of mental illness that consistently included non-psychotic syndromes, 92 per cent of the college-educated with high information exposure and contacts with non-psychotic psychiatric patients turned to non-descriptive criteria in an effort to refine their definitions of mental illness to a point where they would fit their concrete classifications of the examples; at the other extreme, only 78 per cent of the grammar school-educated with low information exposure and no psychiatric contacts did so, while 87 per cent of the intermediate bulk of the population used these logical criteria. Correspondingly, the proportions who contradicted their own logic were: for the most knowledgeable, 86 per cent; for the intermediate, 81 per cent; and, for the least knowledgeable, 61 per cent.

If these results seem in paradoxical contradiction to the usual meaning of informed and knowledgeable, their implications may be made more clear by juxtaposing them to the other, and less marked, tendency. For the general tendency was reversed among the very best informed and oriented sub-groups. Thus, it is apparent, in Table 54, that, among highly informed people who consistently assigned non-psychotic syndromes to mental illness, college-educated people were less--rather than more--likely to use these causally-related criteria of mental illness and to become involved in the kinds of contradiction to which they led. Within those whose usage was

consistently broad enough to contain non-psychotic syndromes, 83 per cent of the college-educated with high information exposure and psychiatric contacts used them, while 89 per cent of the least involved and 91 per cent of the intermediate group did.

In sum, then, everything else being equal, the better-educated, the more informed, those in contact with psychotherapy, and those whose knowledge led to a descriptive definition of mental illness broad enough to include non-psychotic reactions were more likely than their opposites to introduce a variety of logical criteria for defining mental illness and to contradict the criteria they established, except when all these characteristics reinforced each other in the same individuals. The increasing reversal of the general pattern with increasing closeness to psychiatric developments is illustrated below, where it is clear that college-educated people, as a group, were most inclined to introduce considerations which led their discussions of mental illness into difficulty. When information exposure is taken into account, however, this tendency no longer exists, and, as further criteria of awareness of psychiatry are added the pattern is reversed, with the college-educated of great involvement with psychiatry increasingly least likely to become enmeshed in their own arguments.[19]

[19]The same pattern can, of course, also be shown for any of the other variables entering into psychiatric orientation, but the details have been omitted because of their repetitiousness.

	College-Educated	High School-Educated	Grammar School-Educated
Proportion using non-descriptive criteria of mental illness among:			
All members of group	91	89	84
People with high information exposure . . .	89	92	92
People with high information exposure and contact with non-institutionalized psychiatric patients	87	91	93
People with high information exposure, contacts, and consistent use of mental illness to include more than psychosis . . .	83	92	100
Proportion contradicting own logic among:			
All members of group	86	83	74
People with high information exposure . . .	85	87	87
People with high information exposure and contact with non-institutionalized psychiatric patients	81	87	90
People with high information exposure, contacts, and consistent use of mental illness to include more than psychosis . . .	78	80	92

It was, then, the two extremes of the American population--extremes in terms of their interest, information, familiarity and general orientation with respect to problems of mental illness and psychiatry--who found least need to introduce causal considerations into their conceptions of mental illness and who were, therefore, most able to avoid inconsistencies in their definitions. This similarity between the two extremes implies different things, however. As a general rule, the less people said during their interviews the less likely also they were either to advance alternative, mutually inconsistent definitions or to say anything which might contradict whatever definition they had offered. And so, the more articulate groups--the better educated, the better informed, and so on--were, as a general rule, the people who most used and most violated additional causal considerations in defining mental illness, while the other extreme's lesser fluency was reflected in their less frequent use of non-descriptive criteria with

illogical consequences. At the same time, the main purpose of these causal qualifications added to descriptive definitions of mental illness, like the point at which they were generally introduced, was in order to justify the exclusion from the category of mental illness of a particular example whose behavior appeared to qualify as mental illness from the way the speaker had previously defined mental illness.[20] Since the groups typifying the lower

[20]This point was documented more fully in Chapter 5, pp. 63-75.

extreme of involvement with psychiatric problems were not so likely to have started out with a conception of mental illness which appeared to require the conclusion that the less violent or non-psychotic examples were also mentally-ill--that is, they did not so often include non-psychotic syndromes within mental illness or define it as a deviant emotional response, they were not so often confronted with the dilemma of avoiding the logical consequences of their definitions. So, both because they tended to be less articulate and because they did not so frequently define mental illness in a way which made it necessary to add restrictive afterthoughts to it, if no one but the violent paranoid was to be regarded as mentally-ill, the lower extreme of the population made less use of these non-descriptive criteria and expressed fewer inconsistencies.

None of this explanation applies to the upper extreme, however, for these were the people most articulate on the subject of mental illness and most disposed toward a broad inclusion of non-psychotic syndromes within mental illness. The fact that they, too, less often modified their descriptive definitions of mental illness and were less often self-contradictory was, therefore, not so much an act of omission as it was among the lower extreme. Instead, the relative lack of qualifications and contradictions

among the upper extreme suggests that there were within it a disproportionate number of people who had satisfactorily resolved any conflict there might be between intellectual knowledge of the technical denotation of the term, mental illness, and emotional recoil from its implications. Starting from a broad definition of the syndromes assignable to mental illness, they more often adhered to it by concluding that the various examples were mentally-ill. Their more complete acceptance and application of their own definitions was reflected not only in their conclusions about the six examples but in their lesser use of restrictive causal criteria as well.

There is here, again, indication that popular assimilation of technical psychiatric viewpoints on mental illness has been proceeding, even though incompletely. It is clear that only a small fraction of an extreme minority of the American population has fully adopted these conceptions of mental illness to the point where they can function with them completely and in an entirely consistent manner. At the same time, however, it must be recognized that--even though the impact of psychiatric concepts on popular thinking about mental illness has, in the large, resulted in more confusion and inconsistency about mental illness among the groups most likely to encounter psychiatric ideas--knowledge of the technical conceptions of mental illness has not merely contributed to confusion, but has had more positive effects as well. That is, the fact that the groups more informed about psychiatry in one way or another were (if the very extreme minority is left out of account) both the most inconsistent and contradictory and the most likely to classify and interpret human behavior in technical fashion means that there has been partial adoption of this approach to mental illness by people who have encountered it, even though their conflicts and uncertainties--manifested in illogical chopping and

changing--markedly limited the extent of its influence.

Little has so far been said about which of the possible non-descriptive criteria people of different types made use of, just because the choice among them is more indicative of the kind of problem people were trying to resolve than it is of underlying differences in basic orientation. It was pointed out earlier that the basic causal considerations rested on assumptions about the nature of reality, the relation of mind and body and the question of free will and determinism in human behavior, all of which were endemic in the thinking of Western man and called upon as needed to resolve difficulties with the concept of mental illness. Which of these premises was introduced was, therefore, not so much an index of the extent to which it entered into people's thinking as it was an indirect indication of the kinds of difficulties people encountered.

There was, in fact, relatively little consistent difference from group to group in the particular assumptions used, both because the kinds of conflicts to be resolved were pervasive and because each assumption was adaptable to the support of either side of the conflict to which it pertained. Only two tendencies of any note can be singled out. First, the more psychiatrically-oriented were slightly more likely than people who were less familiar with psychiatry to define mental illness as a non-physical disorder. Second, while there was no difference among these groups in the extent to which mental illness was defined by reference to the question of individual responsibility, there was a difference in the way this question was answered, with the better-informed extreme more likely to define morally culpable behavior as mental illness and the least-informed extreme more likely to exclude from mental illness behavior within the individual's control. By way of summary, here are the criteria used by

"involvement" groups:[21]

[21]Because of differences among these groups in the use of any non-descriptive criteria, these percentages are, for comparability, based only on people who used some criterion.

Mental illness is	Highest Involvement	Intermediate Involvement	Lowest Involvement
An organic disease.	22%	23%	19%
A non-physical disorder	40	37	33
Counter-reality, inexplicable behavior	68	71	70
A volitional defect	45	42	33
Involuntary action	27	32	36

Both these differences, of course, derived from the fact that people with high involvement were more disposed than those with low involvement to include non-psychotic syndromes in the category of mental illness. As a consequence, they needed, more often than other groups, both a rationale for including some examples typifying non-psychotic syndromes and a rationale that would permit the exclusion of others. More particularly, the view of mental illness as a moral defect permitted the inclusion of behavior like alcoholism in mental illness, while the non-physical requirement made it possible to exempt the anxiety and psychosomatic manifestations of "George Brown."

Such differences, however, only underscore the fact that, in order to include non-psychotic syndromes within mental illness at all, the most sophisticated group, like everyone else, was largely dependent upon a formulation which made mental illness a moral category and, in so doing, was a source of further confusion both about mental illness, itself, and about the

entire issue of free will and determinism in human behavior." Since the most sophisticated group tried more than other groups to include the non-psychotic, the difficulties inherent in making mental illness both a moral and an illness category were more acutely presented in their thinking than in the views of those who excluded from mental illness any behavior susceptible of moral evaluation. Here, problems of evaluation, attitudes toward responsibility, self-control and loss of control, or, in short, all of the emotions organized around the subject of mental illness emerge, once again, as a crucial, unexamined aspect of popular conceptions of mental illness. So, after a brief concluding note on social factors that have not yet been mentioned, this examination of the more intellectual side of conceptions of mental illness concludes in order to turn, in Part III, to direct consideration of the emotional connotations of mental illness.

Some Other Demographic Factors

While it is felt that all of the more important social determinants of conceptions of mental illness have now been discussed, an attempt has been made, in Tables 61-64, to present, for whatever interest they may have, the relationship of the major elements in conceptions of mental illness to a variety of other social variables of conventional interest. The differences in conceptions which appear there are, for the most part, indirect reflections of underlying differences in the more determining complex of education, interest, information and contact to which detailed attention has been given and should be regarded primarily as sheer description of various segments of the population whose separate views may have practical importance. As a guide to these tables, each of the variables will be commented on briefly:

A. Age differences. It has already been pointed out that older Americans are less well informed about mental illness, less acquainted with extra-mural psychiatry and less disposed to psychodynamic interpretations and psychiatric solutions of human behavior. These differences, as discussed earlier, are not simple reflections of their more restricted formal education, but appear to represent an independently determining factor.

B. Sex differences: As might be expected, there was little or no difference between men and women in thinking about mental illness. Except for the tendency of women to make somewhat more use of psychodynamic interpretations and its accompanying more frequent choice of psychiatry as a corrective solution, there were no essential differences.

C. Racial differences: Non-white Americans were considerably less well educated than whites, and most of the differences between the two groups are simple results of that fact. As a less-well-educated group, non-whites were less acquainted with extra-mural psychiatry, less likely to define mental illness in non-psychotic terms, and less likely to use psychodynamic explanations or to propose psychiatric treatment. Conversely, they more often used organic and innate explanations and more often proposed self-help solutions. At the same time, non-whites reported about as many sources of information about mental illness as whites, and were not notably less likely to perceive mental illness in the concrete examples. Considering the wide differences in education, these similarities imply that, on these points, non-whites surpassed whites of comparable education.[22]

[22]There is, here, some suggestion that non-whites in part used their discussion of the six hypothetical individuals for indirect expression of their hostility toward some patterns of behavior that appeared more typically white and middle-class. The fact that non-whites, despite lower levels of education, contact with psychiatry and general non-psychotic usage, were more likely than whites to perceive mental illness in "Betty Smith's" quiet, well-behaved withdrawal, "George Brown's" anxious striving and "Mary White's" mixture of conventional adjustment, compulsions and phobias at least suggests that non-whites were less approving of or less defensive about these types than were whites. Since this point is, at best, marginal to the main themes of this research, the considerable amount of further comparative analysis of the data needed to speak definitively about the role of a group-conflict element in non-whites' thinking about mental illness has not been undertaken. It is mentioned simply as another illustration of unexplored problems on which the available data can be brought to bear.

D. Religious differences: Largely by reason of higher educational attainment and greater concentration in urban areas, Jews were notably more likely than Catholics or Protestants to be involved in the intellectual trend toward psychiatry, with considerably more sources of information and markedly more contact with psychotherapy than the other religious groups. These factors, of course, carried over to conceptions of mental illness: Jews were most likely to have a generally non-psychotic image of mental illness and to perceive mental illness in each of the concrete examples. Quite consistently, the psychiatric viewpoint was also expressed in Jews' greater emphasis on psychodynamics and psychiatry.

While this fact is partially obscured by the summary nature of the data, Protestants were, on the average, more likely than the other religious groups to emphasize the moral qualities of behavior or questions of free will and responsibility. When differences in age and education among the major religious groups are taken into account, Protestants of each age and educational class were more

likely than comparable Catholics or Jews to conceive of mental illness as a moral defect, to assign causal significance to the will of the individual and to assign to the individual moral responsibility for correcting his own behavior. Since differences in this respect, though quite consistent, were slight, it may be said that adherence to the Protestant ethic was an additional minor determinant of some aspects of thinking about human behavior, which, it may be added, was slightly more influential among regular church attenders than among more nominal Protestants.

E. Occupational differences. Since occupation and formal education are highly interrelated, differences among occupational groups are almost the counterpart of the educational differences which have been discussed at length.

F. Economic differences: Once again, differences among income groups are, for all practical purposes, a simple restatement of educational differences.

G. Regional differences: The population of Eastern and Western areas of the United States appeared to have somewhat more informational orientation to mental illness than the Middle West or South, although these differences were slight and reflected both the higher average educational attainment of the population of the East and West and the presence in these regions of urban centers of psychiatric activity. Conceptions of mental illness also followed about this same pattern, with Westerners generally most likely to perceive mental illness in the six examples, to offer psychodynamic explanations of them, and to make their correction a matter for psychiatry.

H. Rural-Urban differences: Some mention has already been made of the role of urban areas in facilitating the spread of psychiatric information. By reason of both the concentration of the practice of psychiatry in urban areas and the higher average educational levels of urban residents, urban dwellers were better informed and in closer touch with psychiatry. These orientational advantages of urban dwellers were reflected to some extent in their views of mental illness and, more consistently, in their more frequent reliance on psychodynamic explanations and psychiatric correction of human behavior.

CHAPTER 9

THE STATUS OF PSYCHIATRY

Introduction

As we have just seen in the two preceding chapters, mental illness unquestionably emerged as a highly threatening topic to the majority of the American public, notwithstanding the fact that documentation of this conclusion relied exclusively on the kind of feelings and attitudes that people were conscious of and able to verbalize or on only the most immediate inferences from such self-censored expressions. Even within this severe limitation, however, it is clear that discussion of mental illness stirred up fears, anxieties and revulsions, which were expressed both directly and in a good deal of avoidance of or ambivalence and pessimism about questions of its etiology, treatment and prognosis.

This immediate emotional recoil from mental illness, together with derivative and supporting uncertainties about its course, raises still another question; viz., the status of psychiatry and its practitioners in popular opinion. For whatever people's basic reactions to mental illness, it was equally clear from their discussions that they were also widely aware of the existence of a medical field specializing in mental illness and quite willing to delegate to its practitioners and institutions major responsibility for dealing with these problems. At first sight, these popular discussions of the treatment of mental illness already presented might appear by their emphatic reliance on psychiatry to suggest its rather general public acceptance and endorsement, yet it would be difficult to reconcile the implied existence of strong positive convictions about the merits of psychiatry with either the sketchiness of people's knowledge of what they were recommending or their largely negative conclusions about the effectiveness of psychiatric (or any other form of) treatment. In the light of the total context within which people made these superficially favorable references to psychiatry, it appears much more likely that they did not so much represent positive approval of psychiatry as a kind of abdicating selection of psychiatry by default. It is as if people, faced with the dilemma of their need to escape mental illness in conflict with their need to regard themselves as behaving rationally and humanitarianly, made psychiatry their surrogate--a solution which permitted ordinary people themselves to draw away from the dreaded subject of mental illness in good conscience. In such a case, one may wonder if surrogate does not also become something of scapegoat--whether, in short, the whole

negatively-charged subject of mental illness can be turned over so exclusively to psychiatry without an immediate transfer of at least some of the negative affect surrounding mental illness to those who are specialists in it.

If the emotional implications of mental illness and beliefs about its nature and consequences suggest the possibility of a certain public ambivalence --if not outright negative orientation--toward psychiatry, much the same suggestion is implicit in the entire system of popular thought about human behavior. The main tenor of popular thinking, as documented in Part II, involved a view of the determinants of human behavior influenced little, if at all, by the concepts and theories of psychiatry. Both in their pragmatic stress on results rather than causes (which focuses attention on the external and immediate aspects of behavior) and in their moral stress on voluntarism or personal responsiblity (which insists on the possibility and desirability of full rationality and complete self-control in human conduct), popular orientations toward human behavior were quite at variance with the kinds of psychodynamic interpretations characteristic of modern psychiatric theory. And, it may be added, the popular point of view about human conduct was not merely different from the psychiatric one; it was--both in value premises and in intellectual conclusions--peculiarly incompatible with most psychiatric approaches.

So, the two main themes of this research--prevailing interpretations of human behavior and the image of mental illness sustained by them--both lead to the suggestion that psychiatry occupied a most dubious position in popular opinion, a suggestion which is examined more closely in this chapter. Since we are dealing with a system of interrelated ideas--a system which has logic and consistency, however one may rate its validity or desirability, it should come as no surprise that the suggestion which arises as a logical consequence of previously considered aspects of the pattern of thought is indeed borne out empirically by the data to be presented: the field of psychiatry is shown to be little known, little understood, little appreciated, and its lack of popular acceptance proves to derive from the incompatibility of psychiatric approaches to human behavior with those of the general public.

Familiarity with Psychiatry

Throughout their discussions of mental illness, people frequently introduced the specialty of psychiatry as a logical source of help. Without any special prompting, 53 per cent had referred specifically to psychiatrists as the

specialists who dealt with mental illness and another 20 per cent, who apparently were not familiar with the exact term, used such rough equivalents as "mind doctors," or such alternatives as psychologists or psychoanalysts. (See Table 9-1.) Before the topic of information about and attitudes toward psychiatry was even directly raised in the interview, close to three-quarters of the American public had thus indicated at least sufficient acceptance of and familiarity with psychiatry to think of it spontaneously when they were asked about the treatment of mental illness.

The fact that so many people replied "See a psychiatrist" when asked what could be done to treat or prevent either emotional disorders or insanity[1] does not, of course, necessarily imply genuine acceptance and positive support of psychiatry or even any familiarity with psychiatry beyond general recognition of its area of specialization. Since most people approached questions about treatment as tests of their information rather than inquiries into their opinions, the frequent mention of psychiatry was, primarily, a demonstration of the possession of "correct" information, rather than an expression of conviction. At the same time, the very fact that so many people did mention psychiatry in this highly matter-of-fact way is, itself, evidence that, for these people, at least, the subject of psychiatry was not charged with great negative affect either.

Actually, psychiatry was a subject too remote and unfamiliar to most people for very strong feeling to develop about it. Although at least three-quarters of the population knew of the specialty corresponding to psychiatry and

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[1] Spontaneous references to the field of psychiatry actually include all references made in a treatment context during the interview up until the interviewer introduced the term, psychiatrist, in Question 29. The points in the interview at which psychiatrists or their equivalents were chiefly mentioned were:

Prevention of nervous conditions or emotional disorders . .	6%
Treatment of nervous conditions or emotional disorders . .	51
Prevention of insanity	18
Treatment of insanity	23
Handling of crisis on one's family	56
Discussion of concrete examples	13
General discussion of nature of mental illness	3

Of those who made any spontaneous reference, however, 83 per cent mentioned psychiatrists or their equivalents at least once in the series of four questions dealing with the treatment and prevention of nervous conditions and insanity.

at least half could refer to it by name,[2] they were, for the most part, talking of something with which they had had little contact, except through the mass media. For, given the fact that most people's contacts with mental illness had been with institutionalized patients rather than with the non-institutionalized, it is striking that the field of psychiatry was generally defined in terms of the less rather than the more familiar. As was more fully documented in Chapter 7, people thought of psychiatrists for the treatment of nervous disorders and, insofar as professional facilities were involved at all, for the prevention of both nervous conditions and insanity. When it came to the treatment of insanity, however, they tended to think in terms of mental hospitals rather than psychiatrists. Whether because of underlying pessimism about the treatability of the psychotic or because, in the case of hospitalized patients, the institution itself loomed larger in people's attention than the personnel who staffed it, psychiatrists were thus generally spontaneously thought of in the context of treating the non-psychotic or the pre-psychotic rather than the psychotic.[2a] Of the people who referred to psychiatrists, or their equivalents, half cited them only in relation to the treatment of non-psychotic and pre-psychotic disorders; a quarter, in the treatment

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[2] These figures represent minimum estimates of familiarity with psychiatry in at least two senses. First of all, unaided recall is always a more difficult criterion than recognition, so there were an unknown number of people who would have recognized the term, "psychiatrist," who were not able to produce it or popular equivalents for it themselves. Secondly, however, the interview was so structured that people completely opposed to psychiatry were not likely to bring up the subject voluntarily, even though they were quite familiar with it. There were a few people so hostile to psychiatry that they answered a question like "Who could help /people with nervous conditions/ with their problems?" non-responsively in order to express their opposition, as, for instance, the person who said, "Well, I suppose you expect me to answer a psychiatrist, but I think they are no help at all." More typically, however, people who were familiar with psychiatry but opposed to it simply omitted any reference to it as a source of help or otherwise, and are, consequently, excluded from this estimate. Later in the interview, roughly a quarter of those who made no spontaneous reference to psychiatrists, by this or any other name, indicated some knowledge of psychiatric procedure, so that at least another seven per cent of the population had some familiarity with psychiatry in addition to the 73 per cent discussed here.

[2a] It must also be noted that the source of help was explicitly requested only in the questions of the treatment of nervous conditions, and of the handling of a family crisis. In the other contexts, reference to psychiatrists depended on volunteered comment.

of both psychotic and non-psychotic disorders; eight per cent, in the treatment of "insanity" only; and 17 per cent, in ambiguous contexts. This image of psychiatry largely transcended immediate experience: to the extent that they referred to psychiatrists at all, both the educated and the uneducated, the psychiatrically informed and uninformed, and the people who knew non-institutionalized patients of psychiatrists and those who did not were all about equally likely to regard psychiatrists as appropriate only to non-psychotic disorders. (See Table 9-1.)

With the practice of psychiatry so widely equated with the non-institutional treatment of non-psychotic disorders and this an area of psychiatric activity with which most people had no personal acquaintance, there is little wonder that knowledge of psychiatric procedures was sketchy, to say the least. (See Table 9-2.) When asked how a psychiatrist[3] went about helping the people who came to him, 30 per cent could say only that they didn't know or had no idea of what he would do, with about one in four of these people reinforcing their denials of any information about psychiatric practice by referring to their lack of contact with the field. For instance:

> I don't know. (P) There ain't none of them kind of doctors around here that I know of. I've never heard of one.
>
> I just don't know, I've never seen anyone who'd been treated.
>
> I've never been to one, so I just wouldn't know.
>
> He's a mind specialist, so he should be able to help people with the problems they have. (P) I have no idea how he does this; he is trained to help them, that's all I know.

In addition to this large group who frankly admitted ignorance, there were five per cent who gave such vague, evasive answers as to suggest that lack of information was being sheltered behind empty generalities and four per cent who could describe only the conventional practice of medicine, as in these quotations:

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[3]For the 47 per cent who had not already used the term "psychiatrist," themselves, the word was defined to them as "doctors who specialize in treating mental illness and nervous conditions."

> Well, he finds out what's wrong and then he treats that. (How?) I don't know.
>
> They first study their case and then they prescribe a treatment. (What?) The treatment is all different things.
>
> He examines your head, heart, pulse and blood. (Then?) He gives medicine, I reckon, like any other doctor.
>
> He goes to work on you and asks you all kinds of questions, and he writes this down in a book, and then he starts and examines your eyes, and asks you to hold out your hand to see if you're shaking, and he tells you what is the matter. (Then?) I don't know what he does after you tell him everything; maybe he finds you just need glasses or something like that.

These three groups taken together--the "don't knows," the "vague, evasives" and the "non-distinctives"--comprised about two-fifths of the American public. This segment with least information about psychiatry can be further divided into a fifth who made no reference to the field of psychiatry by that or any other name, a tenth who had spontaneously indicated that a medical field specializing in mental illness existed, and a final tenth who had spontaneously identified the field by the term, "psychiatrist." So, it would appear that a fifth of the American public had no awareness of the field of psychiatry, while for another fifth knowledge of psychiatry was pretty much limited either to the fact that a field specializing in mental illness existed or to the term, "psychiatrist," itself.

For the remaining 61 per cent of the American public, psychiatric procedure was pretty much identified with one or another form of psychotherapy. Two per cent described only physical therapies--primarily shock treatment or broader references to institutional care, six per cent mentioned these physical approaches along with psychotherapy, and 53 per cent spoke exclusively of psychotherapeutic approaches. In popular parlance, the key element in psychotherapy was "talk," and the most universally recognized function of the talk was, essentially, diagnostic: the psychiatrist asked questions or permitted the patient to talk freely in order to arrive at an understanding of the basis of his patient's difficulties. Just under half (49 per cent) of the American public--four-fifths of those who had any conception of psychiatric procedures at all--referred to this guided or unguided interview process through which the causes of the problem were to be determined; and almost everyone who referred at all to the locus of these causes in time made it clear that the talk must delve far into the patient's past or early life, if the fundamental source

of his difficulties was to be discovered. (Two per cent referred only to causes that might reside in the patient's present life circumstances; 26 per cent referred variously to "hidden," "forgotten" or "unconscious" causes or to a search for causes into the patient's past, early or entire life; 21 per cent did not refer to and were not asked about the time period in which the causes might be sought.)

For about another fifth of the public, knowledge of psychiatric procedure stopped at this point: they knew that there was talk, and that, usually, the talk sought to arrive at an understanding of the causes of behavior, but, when asked how treatment proceeded once the causes were known or how the talk helped to cure the patient, they either did not know what happened next, were frankly puzzled as to why this talk should help a patient, or took refuge in vague generalities, as in these comments:

> I don't know, I've never been around them. (P) They ask different questions, ask what he thinks. (Then?) It depends on the person; if he wants to be helped, the psychiatrist can help. (How?) I don't know much about this.
>
> The only thing I know is they talk to them, but I don't know after that.
>
> He tries to find out the causes first. (Then?) I don't know what else they do except talk. They don't give medicine, so I don't know how they cure anybody.
>
> He asks questions about his past and his childhood. (Then?) I guess he goes about solving the problem. (How?) It's hard to tell what he does then, unless you have seen one.

So, if a fifth of the American public had apparently no awareness of psychiatry and a fifth knew little more about it than the fact that it existed, there was another fifth of the public whose knowledge of psychiatry could, essentially, be summed up in the one word, "talk."

There remained about two-fifths of the public who had some more detailed information about psychiatric procedure. As they described it, psychotherapy was primarily a highly rational, logical and didactic procedure, in which the psychiatrist, armed with an understanding of the causes of the problem behavior, followed one or several of three possible courses. (See Table 9-3.) First, he could explain, interpret or otherwise communicate to the patient the basic causes of his difficulties, and, once the patient came to see the real causes of his difficulties, his problems were solved: either their very recognition rendered the causes inoperative or the patient needed only

awareness of their causes to be able to deal effectively with his problems himself. This version of psychotherapy is illustrated by these two accounts:

> First he determines the cause, if he can. (How?) For example, psychoanalyzing is a way to find out the cause. (Then?) Then, by explaining the cause, it often helps the patient. (How?) Once he knows the cause, he'll react normally where before he was subject to all kinds of emotional reactions based on a distorted viewpoint.
>
> They lay you down on the couch and ask questions all through your life and form an opinion about your reactions--the questions you ask or the answers you give them. (Then?) Then they tell you what you can do to help yourself. (What?) That's all they do is talk. After he tells you what's been bothering you, it's up to you to do something about it.

In a second version of rational therapy, the procedure was not quite so automatic, but required that the psychiatrist reason with the patient to dissuade him him from his misconceptions or to persuade him to accept a different perspective on his problems:

> They try to talk to him, find out what event or events caused it. (Then?) The rest is simple; the tough part is finding out what caused it--they go way back. (Then?) Then, they work it out. (How?) It's generally a fear, and they prove to him it's groundless.
>
> He talks over the problem. (C) He helps them to see what's the underlying cause of his trouble. (Then?) He tries to talk him out of it, get him on the right track. (How?) I don't know, I guess he tries to educate them, to show them how small his problem really is.

And, in the final version of rational therapy, the psychiatrist implemented the patient's understanding by advice and instruction on techniques of controlling their emotions or of managing their problems:

> By getting them to talk about their problems. (Then?) He can tell them how to treat them and what to do about them. (What?) For instance, if they're afraid all the time, he tells them how to stop being afraid.
>
> They make them talk out, and they lead them on to talk about their lives. (Then?) He sort of shows them what to do through advice.

One or another of these rational procedures, all of which have in common the assumption that the sick person is able to act rationally once he becomes aware of or has pointed out to him, the rational course of action, were mentioned by a quarter of the population, or, roughly, two-thirds of those who

had any clear-cut conceptions of the psychotherapeutic process. For about a fifth of the population (or half of those with some detailed information about psychotherapy), these highly rationalistic, didactic procedures constituted all there was to (or all that was known about) psychotherapy.

In a less frequent, but related and overlapping, version of psychotherapy, the psychiatrist offered the patient practical, commonsensical solutions to the problems he had learned about through the "talk." Here, he might advise patients to overcome their difficulties by taking a vacation and getting away from it all, by developing new interests or hobbies which furnished distraction, by rearranging their living conditions, or by following sensible health rules. For instance:

> They give him proper rest and a little bit of schooling. (C) To make him overlook his petty grievances. (How?) If they were advised to have a hobby or interesting work to occupy their minds rather than just having him just rest.
>
> He makes you talk about everything that has happened to you. I guess he finds out from how much you repeat what's worrying you. (Then?) He tells you how to get rid of your obsession. (How?) Maybe a new job, or more work in the garden, more relaxation.
>
> He advises them to take a vacation and not work as hard; maybe, even, to change to some other line of work.

This practical approach to emotional difficulties was described by a tenth of the public (roughly a quarter of those describing psychotherapy) sometimes in combination with the rational approach, but more frequently as the sole element in psychotherapy.

A final tenth of the public described the process of psychotherapy in terms which introduced affective, emotional, non-rational elements. Primarily, these people referred to one of two things: first, that the psychiatrist provided emotional support, reassurance or motivation for the patient; and, second, that the very process of talking about one's difficulties, especially to an understanding person in whom one had confidence, offered a measure of catharsis or emotional relief. About half the time, the emotional aspect of psychotherapy was introduced as subordinate to the rational or commonsense approach, where, it was felt, the psychiatrist must first win the confidence of his patient in order for his persuasions or advice to have effect. As illustration:

> I guess he first tries to talk to them and put them at ease, to get their life history and try to find out what is causing the worry. (Then?) Then, through gaining confidence in him, he tries to make them forget their problems. (How?) You'd believe what he tells you.
>
> They try to find out what's causing the trouble. (How?) By asking questions and learning about the person's life. (Then?) Then they would just try to build up the person's self-confidence and will power.
>
> They help you to bring out in the open problems you have always been ashamed to admit. (Help?) It's a relief just to talk about them.

Since this has been a long and detailed account of popular conceptions of psychiatry, a quick summary is in order.[4] Of the population as a whole:

20% . . .	showed no awareness of psychiatry
11% . . .	knew only that a field specializing in mental illness existed, but never named it and knew no more about it.
8% . . .	knew that psychiatry was the name of the field specializing in mental illness, but knew no more about it.
2% . . .	referred only to physical therapies--primarily to shock treatment and/or to institutional care.
21% . . .	knew only that psychiatry was somehow a matter of talk.
29% . . .	thought of psychotherapy as an entirely rational and/or commonsensical procedure.
9% . . .	thought of psychotherapy as involving less rational, emotional elements.
100%	

In its way, the fact that some three-fifths of the American public had little or no conception of the practice of psychiatry stands in marked contrast to the fact that some three-quarters of the American public had spontaneously proposed psychiatry when considering the treatment of mental or emotional illness. As this disparity implies, many people had suggested psychiatry in the handling of "nervous conditions," "insanity," or behavioral crises in family members without any clear idea of what they were proposing. This point was, in fact, foreshadowed by the large extent to which people who recommended psychiatric treatment for either "nervous conditions" or "insanity" were unable to add very much substance to the word "treatment." (See Tables and .) Only about half the people who cited psychiatry as a

[4] In the summary which follows, the six per cent of the public who mentioned both psychotherapy and physical therapy are distributed according to their descriptions of psychotherapy. They are divided as follows: three per cent, "talk"; two per cent, "rational and/or commonsensical procedure"; and one per cent, "emotional."

source of help were able, anywhere in the interview, to say anything specific about its procedures, although people who knew even the word, "psychiatry," were, as shown below, a good deal more knowledgeable than either those who made less exact references to the profession or those who never mentioned psychiatry at all:

Limit of Knowledge of Psychiatric Procedure	Spontaneously Referred to Psychiatric Personnel: Used Exact Term, "Psychiatrist"	Spontaneously Referred to Psychiatric Personnel: Used Other Terms Only	Did not Spontaneously Refer to Psychiatric Personnel
No (further) information . . .	15%	54%	74%
Psychiatry is physical treatment	2	2	1
Psychiatry is talk	27	17	12
Psychotherapy is rational . .	41	22	11
Psychotherapy involves emotional elements	15	5	2
Total	100%	100%	100%

Or, to put it another way, about everyone who had even the vaguest idea of what psychiatrists do--91 per cent of those with any specific knowledge of psychiatric procedures and 83 per cent of those with only vague information--recommended their services, but so did half the people (48 per cent) who knew nothing about them.

There is involved here a kind of factual acceptance of the existence of the profession of psychiatry, which was, if anything, bolstered by the very lack of further information about it. That is, in the absence of definite knowledge of psychiatry, people tended to view it simply as a branch of medicine with a special field of competence and to cite psychiatry for mental illness in much the same way as a person might mention a cardiologist in connection with heart disease. It was not so much a matter of being for or against psychiatry--or cardiology--as it was a demonstration of awareness that medicine is so organized that certain sorts of problems are conventionally referred to certain sorts of specialists. In fact, it appears that the very existence of the specialty of psychiatry was sometimes arrived at as a kind of logical deduction from more general knowledge of the practice of medicine or, as one person put it, "They have specialists for everything else, so there must be a doctor for nerves, too." At any rate, as the data just presented above make clear, people who talked about specialists in mental or nervous

illness without using the term, "psychiatrist" usually knew or inferred little more than their existence.

Aside from the fact that three-fifths of the American public had little or no conception of the practice of psychiatry, two things stand out about these popular discussions of psychiatry. One of these is the relative hesitancy and uncertainty with which even people who had some ideas about psychiatry expressed them; the other is, correlatively, the sources from which their ideas were derived.

As was probably evident in the illustrative quotations cited, comments about psychiatry were replete with phrases like, "I don't know of my own accord, but I've heard...," "I'm not sure, but I think...," "I've had no experience with their work, but I presume...," "I haven't the least idea, but according to what I've seen in the movies...," I guess," "I imagine...," "I suppose...." Quite apart from the large sub-group who had no information about psychiatry, almost all of whom explicitly admitted their lack of information, these phrases indicative of doubt and uncertainty also crept into the remarks of substantial proportions of the minority with rather detailed information about psychiatry:

Limit of Knowledge About Psychiatry	Proportion explicitly indicating either lack of or uncertainty about the accuracy of own information about psychiatric procedure
No knowledge	93
Field of specialization exists . .	89
Psychiatry is name of field	85
Psychiatry is physical therapy . .	46
Psychiatry is talk	61
Psychotherapy is rational	38
Psychotherapy involves emotional elements	29

Overall, 63 per cent of the American public made it clear that they were aware of hiatuses in their knowledge of psychiatry, and 37 per cent of those classified as having some information verbalized such doubts.[5] Probably nowhere

[5]As shown in Table 9-2, expressions of doubt about the completeness and reliability of their information about psychiatry ranged from a "don't know" as the entire answer to the question, and simple denials of further information when an interviewer tried to clarify a relatively vague answer, through frank acknowledgments that the respondent did not consider the procedures he had described sufficient to cure a patient but lacked information about the crucial missing steps, to the less direct but still explicit kinds of hesitancies and doubts about their information just described.

else in the interview was so much uncertainty so freely expressed.

As the remarks themselves make clear, these uncertainties were largely a reflection of the fact that people were remote from the kind of psychiatry they were discussing and had neither first-hand experience nor the kinds of alternative sources they considered reliable on which to draw. They were, instead, deriving their descriptions of psychiatry from two main sources. On the one hand, their ideas were drawn from the mass media and, in particular, from the kinds of dramatization of psychotherapy presented in a number of then -current and highly successful movies. In some of the depictions of psychiatry quoted, it is possible to see, just beneath the surface, almost the exact movie the person was thinking of--such portrayals as "Mine Own Executioner," "The Dark Mirror," "Spellbound," and, no doubt, a number of other mass media dramatizations of the facts of psychiatry. Certainly, there was, in people's discussions of psychotherapy, a rather disproportionate emphasis on the search for the hidden causes of problematic behavior in the patient's early life--disproportionate both because the process of arriving at a causal explanation was so frequently the only element in psychotherapy people were aware of and because the emphasis on the past was quite at variance with the same people's more usual approach to causal explanation of human behavior, where behavior tended to be interpreted in terms of much more immediate events and without recourse to symbolic meanings. Thus, people who knew only that psychotherapy consisted of a process of talk to determine these hidden, past causes of behavior explained 26 per cent of the concrete examples of human behavior they discussed in terms of the psychodynamics of childhood, while those who described psychotherapy without reference to the process of discovering causes in the person's early life used this type of explanation in 25 per cent of the instances they discussed. While it cannot be completely demonstrated statistically, it seems likely that both the emphasis on early psychogenic causation and the less frequently-mentioned belief that instantaneous and dramatic recovery followed the psychiatrist's revelation or elucidation of the true causes to the patient derived from the movies, which typically did, in fact, present this image of the psychotherapeutic process.

On the other hand, and even more markedly, when people had to "guess," "imagine," or "suppose" what a psychiatrist would do for an emotionally disturbed person, it is not surprising that they ended up by attributing to psychiatrists whatever actions they considered appropriate to the correction of

behavioral problems. In the absence of definite information to the contrary, many people simply assumed that psychiatrists would approach behavior in the same way they did and would, therefore, deal with it as they would. While, admittedly, it is difficult to describe psychotherapy without sounding overly rationalistic and there are some schools of therapy which place more emphasis on rational persuasion and practical advice than others, still, the stress on the rational and the didactic in popular discussions of psychotherapy was too great to be accounted for either by difficulties of language or by greater acquaintance with particular forms of psychotherapy. Rather, if the most frequently-mentioned elements in psychotherapy had the psychiatrist reasoning with his patient, "talking him out of" his unhealthy state of mind, and giving him helpful advice, it was not so much that these happened to be the details of psychiatry specifically familiar to people as it was a generalized projection onto psychiatrists of the only modes of dealing with human behavior that occurred to them.

A great variety of evidence, in fact, supports this interpretation. First, there is the fact that the people who were closest to psychiatric influences were most likely to depart from the highly rational or commonsensical image of psychotherapy. As we have seen before (Chapter 6), it was the college-educated, those most exposed to information about mental illness and those with some acquaintance with non-institutional psychiatry--a small group summarily referred to as those most involved with psychiatric trends of thought --whose thinking about mental illness and about human behavior generally was most likely to reflect at least partial assimilation of psychiatric points of view. And it was, of course, these same classes of the population who indicated greatest familiarity with psychiatric technique. Details of these differences are presented in Tables 9-1 to 9-4, but, from the group with most involvement to the group with least involvement, the proportions who spontaneously referred to the profession of psychiatry as a source of help with mental illness declined from 97 to 44 per cent; the proportions spontaneously familiar with the word "psychiatrist," from 91 to 18 per cent; the proportions with any substantive knowledge of psychiatric procedures, from 95 to 25 per cent; and the proportion with more than a vague conception of psychotherapy, from 70 to 12 per cent. More relevant for the present discussion, however, descriptions of psychotherapy in purely rational or commonsense terms outnumbered those in which non-rational, emotional factors played a part by about

two to one in the most involved group, but this ratio rose to about five to one among the least involved. (For the bulk of the population the rational outnumbered the emotional by slightly more than three to one.) In other words, there was a shift toward regarding psychotherapy as a wholly rational process as actual closeness to and, presumably, genuine familiarity with psychiatry decreased. And, quite consistently, the people who indicated that they were uncertain or unsure of their accounts of psychotherapy--the people who were "guessing," "imagining" or "supposing"--were the most likely of all groups to arrive at a rational image of the psychotherapeutic process:

Evaluation of Own Information	Ratio of rational and/or commonsensical descriptions of psychotherapy to those involving emotional elements
Indication of speculative, uncertain quality of information	4.4
Indication of lack of further information	3.8
No reference to adequacy of information	3.1
Indication that information is regarded as adequate	1.6

This tendency to identify professional psychotherapy with the rational means by which individuals seek to control themselves or to influence one another's behavior is also suggested by earlier data. In Part II, it was apparent that, insofar as people discussed modes of controlling problematic behavior at all, these methods differed more in whom the agent applying them was conceived to be than in what the corrective agent did. Whether the hypothetical individual was thought of as able to correct his own behavior, or as needing the exhortations and persuasions of his family and friends, or as requiring the professional assistance of psychiatrists, the basic mode of control relied on rationality, and these three sources of help were viewed as largely interchangeable stimulants to self-control. In much the same way, discussion of the treatment of "nervous conditions," presented in Chapter 7, assigned very little by way of special function to psychiatrists. With the sole exceptions of the rather vague process of talk by which the psychiatrist discovered the hidden causes of behavior and the concommitant spontaneous type of recovery which depended only on exposing those causes to the "nervous" patient, there was no step in the psychotherapeutic process, as popularly conceived, which was not assigned more frequently to other sources of help

than it was to psychiatrists. As pointed out earlier, aside from this element of psychiatric concern with deep, early causation--an element largely unassimilated into the rest of popular thinking about human behavior, psychiatrists appeared merely to unite some of the functions of family physician with some of the functions of friends and relatives, without in any way displacing either. The basic viewpoint appeared to be that what psychiatrists do for a person with a problem is not so very different from what anyone with the time and interest might equally well do.

If popular accounts of psychiatric procedure thus appeared to contain a subtle disparagement of the skills of psychiatrists, it was frequently expressed in terms which superficially suggested over-estimation of the power and infallibility of psychiatry. Certainly, one recurrent theme in all discussions of psychiatry was an emphasis on the certainty, speed and ease with which emotional difficulties--even those as extreme as our hypothetical paranoid man or schizophrenic girl--could be dealt with by psychiatry. Speaking of the paranoid example, one respondent said, "A psychiatrist could help him easily"; and another person concluded, "A couple of visits to a good psychiatrist who could find the cause of his hatreds and suspicions would clear it up." Of the schizophrenic girl it is said, "A psychiatrist could treat her and bring her right out of it," or "A psychiatrist could probably make a normal person of her in a short time." And the problem child "could be straightened out, in no time at all," and so on.[5a] Despite their suggestion of exalting psychiatrists to the status of miracle workers, remarks like these stemmed more immediately from the rationalistic cast of popular psychology with its extreme under-estimation both of the seriousness of emotional disorders and of the difficulty of modifying them. As one respondent replied to the question of how the patient was helped by the search for causes in the past, "Oh, the rest is simple. The tough part is finding out what caused it--they have to go way back." Thus, even apparently highly positive endorsements of psychiatry contained the same reduction of psychiatric procedures to everyday, common sense measures.

[5a] Similar comments appear in Chapter 4, pages 37, 51, and 101. The tendency to regard psychiatric therapy as sure, fast, and simple, apparent in these remarks, was not separately coded, but it can be said that at least two-thirds of the references to the desirability of psychiatric treatment for one or another of the six examples occurred in contexts where the respondent was denying or minimizing the seriousness of the problem under consideration.

In sum, the American people had relatively little information about psychiatry. Such ideas of psychiatric practice as were current tended to assume that the field of psychiatry generally accepted and proceeded on the same beliefs in human rationality and in the ability of the individual to control his behavior whenever it was not rational that permeated popular thinking. On the one hand, knowing nothing at all about psychiatry or assuming that psychiatry "naturally" viewed human behavior in the same ways they did minimized, for most people, the conflict inherent in the essentially divergent conceptions of psychiatric theory and popular thinking and permitted the passive acceptance of psychiatry as a medical specialty without acute awareness of its philosophical implications. On the other hand, however, this tacit solution effectively insulated the thinking of most people from any challenge from or possible modification by psychiatric theories of human behavior, and, at the same time, essentially denied to psychiatry any specialized knowledge, expertness, or skill.

As this very summary of the state of public knowledge about psychiatry suggests, a certain ambivalence about psychiatry runs through popular thinking. As we examine, in the following sections, people's views of the relevance and applicability of psychiatry for themselves and others, it will become ever increasingly apparent how the direct, superficial acceptance by the public of the existence and usefulness of psychiatry is mingled with a less direct but, perhaps, deeper lack of enthusiasm and respect for the field, if not with a fundamental though concealed resistance and rejection of it.

The Place of Psychiatry

As already suggested, psychiatry was popularly deemed applicable primarily to nervous conditions and pre-psychotic disorders. Since the great majority of the public thought of nervous conditions as themselves forerunners or early stages of psychoses, psychiatry was, thus, essentially regarded as a form of treatment adapted to the beginning phases of the development of a psychosis. In fact, in the light of such understanding of the therapeutic process as the public possessed, psychiatry necessarily appeared to be limited to those forms or stages of illness when the patient was still sufficiently possessed of his reason to be amenable to "talk"--that is, to rational persuasion and commonsense advice.

Given this basic image of mental illness as a sequence of development, it did not require very much detailed knowledge of psychiatry for people to decide the point along the way at which psychiatric treatment should be introduced. In contrast to the 30 per cent who explicitly stated that they did not know anything of psychiatric technique, only nine per cent said they didn't know, when asked "As you see it, how serious a problem should a person have before he goes to see a psychiatrist?" Instead, the leading answer to this question grew directly out of the prevailing image of mental illness. (See Table 9-5.) A plurality of 46 per cent simply endorsed the importance of early treatment in mental as in other illness, remarking that a person should go to a psychiatrist without delay--before his problem became serious, at the very first sign or symptom or at least as soon as the person realized that there was something wrong:

> They ought to go before it gets serious, the sooner the better. The sooner he goes and finds out what's wrong, the sooner he may get well.
>
> He should go right away to get cured.
>
> At the beginning before it even got serious. (C) After the first two weeks, I'd say.
>
> I think the first real signs of it is the best. (Why?) I think if you get it in time there's a chance for help, and if you let it go too long it's past helping.
>
> I don't think it should be very serious. They should go at the very first indication of anything being wrong, when the first symptoms show up. (Why?) This will give them a good chance to nip it in the bud and not let it get aggravated.
>
> I don't think he should be serious at all; when he first discovers it, he should go. (Why?) If he waited too long, help may not be able to do him no good.
>
> The very first time they suspect they might need it. My experience has been that every day you wait makes it a lot harder to do anything with.

This declaration in favor of prompt and early treatment was, of course, a rather programmistic position. It often appeared to be suggesting that the onset of mental illness was signalized by as definite, unmistakable symptoms as an acute contagious disease, and its actual significance entirely depended on what the people who espoused it assumed to be the "first signs" of mental illness and on how adept they were at perceiving them. It was, in consequence, a kind of formal and schematic acknowledgment of the importance of psychiatric treatment which required neither awareness and understanding of emotional

disorders nor knowledge of psychiatry for its endorsement. Significantly, if the people whose lack of information about psychiatry led them to say "don't know" to the question of when to see psychiatrists are excluded, the "without delay" position was more often espoused by persons with no knowledge of psychiatry than it was by people who had some information--55 per cent as against 40 per cent.

No other way of defining the appropriate time for psychiatric treatment was mentioned with anything like the frequency of this general support of early treatment. In fact, all of the three alternative positions together had a frequency somewhat lower (43 per cent) than the dominant emphasis. First among these more minority viewpoints, however, was one which was essentially the opposite point of view to "treatment without delay." This position, here dubbed "treatment in due course," was taken by 18 per cent of the American public. It consisted more or less explicitly of a belief that people generally should go through a logically ordered series of steps in trying to cope with their difficulties--first, they may try to work out their own problems, then they may turn to their families or friends for help, next they may go to a minister or a family doctor for counsel and, only after all these less extreme measures have proved ineffective, does psychiatry become appropriate. So, these people said, the problem ought to be getting pretty serious before a person goes to a psychiatrist, at least serious enough so that his friends or physician have failed to help or his doctor advises or prescribes it. For the most part, people in this position did not appear to be implying anything more than this sense of an appropriate sequence to action and often thought of it as providing a channel that insured prompt, early treatment, but an occasional person made it clear that psychiatry was so fundamentally unacceptable that it should be regarded as the last resort, not to be tried until every conceivable alternative to it was exhausted:

> Any problem that cannot be answered by the person or his relatives should be taken to him at once before anything else develops.
>
> When the local family doctor can't do anything for it and the case is getting serious.
>
> When his doctor feels he has a mental condition and should see one, he should go at once.
>
> I don't think you should go before your own doctor suggests it. (Why?) He'd know whether you need one or not.

Not if you could possibly avoid it. (When?) I guess when everything else was tried and didn't do any good.

This "due process" position was, in some respects, a more realistic one than the alternative of "without delay." It was, for instance, a fairly accurate depiction of the processes people appear to go through before reaching a psychiatrist. In the present research, which probably overstates the case at that, only 17 per cent named psychiatric consultation as the first step they would take in a family crisis, as compared with 39 per cent who said they would go to psychiatrists as a later step, after trying lay persons or physicians or both. More recent work by Clausen and his associates on the question of what the families of mental patients actually did suggests that this hierarchical process is well-nigh universal.[6]

The remaining two positions on the appropriate time to consult psychiatrists focussed somewhat more on the nature of the problem, though again in contrasting ways. The first group--13 per cent of the public--felt that a person should see a psychiatrist at the point where he no longer felt able to cope with his own difficulties or where various, largely subjective symptoms of inner stress, emotional conflict, and disturbed feeling emerged. The second group--12 per cent of the public--focussed on the external manifestations of disturbance in behavior, feeling that a person should be sent to a psychiatrist when other people noticed oddities in his behavior or when his actions threatened or disturbed others. These two points of view were typically expressed as follows:

Personal Strain

I think before the problem gets too serious. (When?) As soon as it becomes apparent that it is a problem that won't work itself out, something the person can't handle for himself.

When his problems become too large, just beyond the person to solve.

If it keeps them awake nights, makes them feel irritable or emotionally insecure, they should go to a psychiatrist. (Why?) If it persists, it could lead to a nervous breakdown; it leads to something more serious if not cared for.

Before he starts acting queer. (C) Some wait too long; they can tell themselves when their nerves are on edge and that is the time to go.

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[6]John A. Clausen and Marian Radke Yarrow, "Paths to the Mental Hospital," Journal of Social Issues, Vol. 11, No. 4. (1955), pp 25-32.

External Effects

As soon as you notice that this person is not acting just right.

Pretty serious. (C) To the point where other people could see he was acting funny. (Why?) You wouldn't know there was anything wrong until then.

I think when he starts disturbing others and is affecting their happiness as well as his own.

When people act abnormal--do odd things seriously harmful to others, then it's time to do something.

It is apparent that the emphasis on personal strain was receptive to the psychiatric treatment of emotional disorders, although this position was sometimes complicated by a high positive value placed on self-reliance and some negative feelings about a person who gives up and admits that he needs help. It did, however, contrast rather sharply with the emphasis on external behavior, where the main concern appeared to be detection and treatment of emergent psychotic trends.

Despite real differences in these four orientations toward the proper place of psychiatry, one similarity united all of them. With the exception of the quite small group (six per cent) who either entirely opposed any use of psychiatry or reluctantly conceded its use as a last resort, the basic intent lying back of all the varying formulations was that people should be referred to psychiatrists as soon as psychiatric treatment was appropriate to their disorders. It is significant that this discussion of the proper place for psychiatry centered almost entirely around the tactics of treatment and involved little direct expression of any attitudes toward psychiatry, even though this was the first point in the interview at which people were directly invited to indicate their feelings. Thus, just over half (55 per cent) of the population made explicit the considerations which entered into their formulations of when people should be referred to psychiatrists, and these dealt almost exclusively with the appropriateness of treatment. Some 40 per cent of the public (three-fourths of those making any explanation) said merely that treatment at the point they chose would be more effective than treatment at some other time or would prevent the development of the disorder into a form more serious and more difficult to treat, if not into an incurable psychosis. Of the explanations advanced by people who said treatment should be sought

"without delay," 95 per cent reflected this concern with prompt treatment, but so did 60 per cent of the explanations advanced by people who looked for symptoms of inner stress, and 57 per cent of those advanced by people who depended on symptoms of external behavior. It was only in the "due course" group that the need for early treatment assumed a secondary role, and even here 23 per cent of the explanations indicated a concern to insure channels of prompt referral of appropriate cases. Alternative and secondary explanations similarly involved direct concern with treatment and were only obliquely evaluative of psychiatry. For example, the "due course" position rested primarily on the feeling that until the more usual kinds of help with problems offered by family, friends and physicians were tried there was no way of knowing that psychiatric assistance was appropriate (45 per cent of the explanations of this position), while the second most frequent explanation of the "inner stress" position (28 per cent of these explanations) was the comparable view that until the individual exhausted his capacity to help himself, outside asisstance was inappropriate, and, in much the same way, 27 per cent of the explanations of those who chose "external effects" as their referral point rested on the belief that there was no way of telling any need for treatment existed until these overt indications appeared.

Once again, then, it was pretty well taken for granted popularly that the field of mental illness was legitimately preempted by psychiatry. With this tacit assumption, the answer to "when to see a psychiatrist" became simply "when the evidence indicates a person has or is developing a mental illness." The ensuing discussion--whether people espoused psychiatric treatment with or without delays, for emotional conflicts or for socially-disturbing behavior--had less to do with any specific beliefs and feelings about psychiatry itself than with more general conceptions of the nature and course of mental illness. As may be seen in the summary data below, the general outlines which emerged were entirely consistent with prevailing conceptions of mental illness, but did little to illuminate public thinking about psychiatry. In somewhat cursory fashion, these data underscore again that emotional problems were not regarded as particularly serious by the American public, particularly when they first occur and even when their symptoms are such as to suggest actual or potential psychotic difficulties to more sophisticated observers; they were still not regarded as serious, though somewhat more so, when their consequences begin to impinge on other people and when the person affected has to confront his own inability to manage himself; they became increasingly more serious as

family, friends and physicians prove unable to offer effective assistance, but were not usually regarded as serious until other people--particularly physicians--conclude that every possibility of remedy or improvement except psychiatry has been exhausted.

	Proportion with Indicated View of Problem among Respondents Believing Psychiatrists Should Be Consulted:[7]					
	Without Delay	With Personal Strain	With External Effects	In Due Course	Never	All Respondents
Seriousness of Problem at This Point						
Not serious	33	11	7	8	-	28
Serious	-	4	2	8	-	7
Total mentioning seriousness	33	15	9	16	-	35
Per cent "serious," of those specifying degree	-	25	21	53	-	20
Symptoms Characteristic at This Point						
Inner stress only	19	26	15	10	-	17
External behavior	16	14	44	16	-	21
Total mentioning symptoms	35	40	59	26	-	38
Per cent "external" of those describing symptoms	46	36	74	62	-	54
Reason for Choosing This Point						
Treatment Considerations						
Early treatment more effective, prevents more serious or incurable disorder	72	19	17	12	-	40
Psychiatric treatment not indicated (needed) before this point	1	9	3	23	-	6
Need for treatment not apparent (perceived) before this point	1	1	8	4	-	2
Feelings about Psychiatry						
Favorable	2	1	1	*	-	1
Unfavorable	-	1	1	8	91	5
All other reasons	*	1	*	4	-	1
Total mentioning reasons	76	32	30	51	91	55
Per cent "treatment" of those giving reasons	97	91	93	76	-	88

[7] Respondents whose classification into a position on consulting psychiatrists was determined by the view being considered are excluded from the category in computing these percentages to avoid circularity. Thus, those who said merely that people should consult psychiatrists "befire it is serious" are not included in the "Without Delay" group in reporting seriousness, and those who said only "not unless it is serious" are similarly excluded from the "In Due Course" group. Comparably, on presenting the symptoms described as characteristic of the referral point selected, those whose entire answer was merely a listing of the symptoms calling for psychiatry are omitted from the groups--"With Personal Strain" and "With External Effects"--to which they were assigned.

The field of psychiatry itself was only most tangentially evaluated in approaches of this kind, and the widespread non-critical acceptance of psychiatry obliquely implied by them must be qualified in the light of all the ambivalences which popularly surrounded the topic of mental illness. If the general belief that anyone should get to a psychiatrist as soon as his need for treatment was established suggests public acceptance of pshcyiatry, it must be placed in the context of highly constricted definitions and perceptions of treatment needs. People who actually had no conception of mental illness apart from psychosis, people who in practice recognized only the more violent forms of psychosis as mental illness, people who thought of psychiatry as relevant only to psychosis--all these groups encountered little difficulty in harmonizing these views with the position that psychiatric treatment should be sought "without delay, at the very first sign or symptom." As shown below, people of each of these basic views of mental illness were about as likely to espouse the "early treatment" doctrine as were people who thought of mental illness in more inclusive terms:

	Proportion Classed in "Without Delay" Position	
	All Respondents	Respondents with An Opinion on When to See Psychiatrist
General Usage of Term, Mental Illness		
Consistently limited to psychosis	43	52
Inconsistently limited to psychosis	49	54
Inconsistently included non-psychotic disorders	47	51
Consistently included non-psychotic disorders	46	49
Concrete Perception of Mental Illness		
No apparent perception	42	49
Limited to violent psychosis . .	46	50
Limited to psychosis generally .	47	49
Included neurotic or personality disorders	53	55
Context of Spontaneous References to Psychiatry		
Psychotic only	51	54
Pre- or non-psychotic included .	49	51
Ambiguous family crisis only . .	47	50

It was, thus, quite possible to express views that implied acceptance and support of psychiatry even while placing stringent restrictions on its use,

and to do so with no overt hostility and, indeed, with no awareness that one's thinking in any way diverged from what psychiatrists might regard as full public acceptance.

The Relevance of Psychiatry

Popular rejection or avoidance of psychiatry was, therefore, primarily a matter of default, a passive resistance, rather than organized, positive opposition to its doctrines and procedures. It consisted, for the most part, in a simple failure to think of psychiatry as in any way relevant to large areas of human behavior that would be otherwise defined by psychiatry. While people repeatedly reiterated their matter-of-fact willingness to accept psychiatry in the areas to which it was relevant, they negated this acceptance by almost never defining problematic behavior in ways which would make psychiatry relevant. On the one hand, psychiatry was always the appropriate remedy for behavior so disordered as to be defined as mental illness, but, on the other hand, behavior was, in the popular view, seldom sufficiently disordered to transcend the popular reluctance to define it as mental illness. As a result, psychiatry, though certainly appropriate to mental illness, was rarely relevant to human behavior.

This alternation between positions which seemed to suggest public acceptance of psychiatry and those which implied rejection or avoidance can be seen throughout this report, with its occurrence depending on only one factor: When mental illness was postulated or implied in the questioning, people referred quickly and matter-of-factly to psychiatry; when people were left free to decide for themselves how human behavior should be evaluated, they rarely found a place for psychiatry. Summarized in this way, there is really nothing contradictory or paradoxical in the fact that a majority of the public volunteered the psychiatric profession as a logical source of help with "nervous conditions," while only two per cent referred to psychiatry when discussing a "George Brown," whose behavior roughly approximated the popular image of a "nervous condition." It should, in fact, come as no surprise that, although a majority of the public introduced psychiatrists into a situation where a family member began showing signs of mental illness and there was even higher agreement on the advisability of people generally seeking psychiatric assistance in such circumstances, relatively few saw any need for psychiatry either in themselves or in their circle of acquaintances.

When asked whether they knew any people who "would be helped if they'd see a psychiatrist," only 28 per cent of the American public indicated that they perceived any unmet needs for therapy in the people about them. In contrast, almost three times as many people (78 per cent) had at one time or another known someone whose need for psychiatric treatment was sufficiently great to lead either to institutionalization or to extra-mural treatment. The disparity between these two figures need not, of course, imply that the bulk of the American public was systematically imperceptive of psychiatric needs until the fact of treatment's being instituted made their existence incontrovertible. Logically, at least, these results might mean that most people did know others who presented psychiatric problems, but felt that the necessary treatment was being received. There is, however, abundant evidence that the former interpretation is correct: most of the public simply felt that no one they knew should be defined as a psychiatric problem.

In proof of this assertion, it was primarily the relatively small segment of the American public involved with the current of interest in psychiatry who saw people around them in need of treatment but not receiving it. The proportion who said they knew people who could benefit from treatment declined from just over half the college graduates to less than a fifth of those with only grammar school education. Or, exactly half the group with relatively high exposure to information about psychiatry perceived unmet psychiatric needs in their own social circles, as compared with 15 per cent of those with least exposure. Most compellingly, it was the people who already knew some persons in non-institutional psychiatric treatment who were most likely to see the need for treatment in still others. In general, then, contact with persons under psychiatric care appeared more often to sensitize people to the needs of non-patients than to suggest that existing needs were being met. To summarize:

	Proportion Knowing People Not Now Receiving Psychiatric Treatment Who Would Benefit from It
Contact with Psychiatric Patients	
Knew non-institutionalized patients	
Intimate associates (immediate family, close friends)	55
Less intimate associates (other relatives, acquaintances)	41
Knew institutionalized patients only	
Intimate associates	27
Less intimate associates	25
No contact reported	14
Exposure to Information about Psychiatry	
High (6-9 sources)	50
Middle (3-5 sources)	27
Low (0-2 sources)	15
Formal Education	
College-graduation	53
Some college	39
High school graduation	34
Some high school	26
Grammar school graduation	19
Some grammar school	18
Summary of Psychiatric "Involvement"	
Highest (college plus high exposure plus non-institutional contact)	69
Intermediate (all other)	27
Lowest (grammar school plus low exposure plus no contact)	8

There is here an almost complete parallel to the conclusions drawn from popular reactions to the six hypothetical individuals dealt with at length in Part II. Just as people were not, for the most part, inclined to read mental illness into the behavior of the imaginary characters except when the behavior was too socially-threatening to be ignored, so they were inclined not to judge the people they knew in terms which might make psychiatry a relevant consideration. Quite consistently, the people who did define mental illness broadly and, especially those who applied their more inclusive concepts of mental illness to the concrete examples were a good deal more likely to perceive unmet psychiatric problems about them, even when due allowance is made for differences in background and experience:

	Proportion Knowing People Not Now Receiving Psychiatric Treatment Who Would Benefit From It
General Usage of Mental Illness	
Consistently included non-psychotic syndromes . .	37
Inconsistently included non-psychotic syndromes	27
Inconsistently limited to psychosis	18
Consistently limited to psychosis	18
No impression	9
Concrete Perception of Mental Illness	
Consistently extended through neurotic example. .	44
Limited to psychotic examples	31
Limited to violently psychotic example	26
No concrete perception	17
Not consistently classifiable	33
Summary	
General usage consistently included non-psychotic	
And concrete perceptions consistently extended through neurosis	57
But concrete perception not consistently extended through neurosis	32
General usage not consistently non-psychotic	
But concrete perceptions consistently extended through neurosis	32
And concrete perceptions not consistently extended through neurosis	23
Respondents with HIGHEST "involvement" and with consistent inclusion of non-psychotic syndromes in:	
Both general usage and concrete perceptions .	79
Either general usage or concrete perceptions.	74
Neither general usage nor concrete perceptions	57
Respondents with INTERMEDIATE "involvement" and with consistent inclusion of non-psychotic syndromes in:	
Both general usage and concrete perceptions .	54
Either general usage or concrete perceptions.	31
Neither general usage nor concrete perceptions	23
Respondents with LOWEST "involvement" and with consistent inclusion of non-psychotic syndromes in:	
Both general usage and concrete perceptions .	20
Either general usage or concrete perceptions.	11
Neither general usage nor concrete perceptions	7

It would, indeed, be startling if this correspondence did not exist, for the discussion of the meaning of mental illness in Part II and this more immediate question of whether people thought any of their friends or acquaintances could be helped by psychiatry are fundamentally concerned with the same subject--the American public's characteristic approach to the behavior of people around them. Part II established that the typical American approach to human behavior relied on a scheme of interpretation, explanation and control quite different from and little influenced by psychiatric theories. The present data independently confirm that psychiatry was irrelevant to everyday life in the thinking of most people. The minority who did find psychiatry applicable to the people around them differed from the general tendency not merely in this specific respect but in their entire approach to human behavior and the place of mental illness within human behavior as well.[8]

Significantly enough, when this more psychiatrically-influenced minority went on to explain why it was, as they saw it, that people in need of psychiatric therapy did not obtain it, their analysis moved in much the same direction as this one. That is, the problem of unmet needs for psychiatric care was, in their view, sometimes, but not usually, a simple matter of lack of essential information; sometimes, but even less often, a matter of objective barriers in the way of seeking treatment; and, most usually, a matter of refusal to see the relevance of psychiatry, a resistance to defining personal problems as psychiatric on the part of people whose basic thinking about human behavior attached highly unacceptable emotional connotations to the category of behavior relegated to psychiatry. (See Table 9-6.)

About two-fifths of the group who saw the need for treatment in people around them felt that these people lacked certain items of information essential to taking action, primarily that the very people who needed treatment did not know enough about psychiatry and the nature of emotional problems to draw the correct conclusions about themselves. While this point of view appeared to suggest that people would seek needed psychiatric therapy if only

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[8]These differences have been represented here by differences in conceptions and perceptions of mental illness, but it should be remembered that these in turn imply (and might equally well have been represented by) substantial differences in general orientations toward the determinants of human behavior, and in attitudes toward mental illness.

they were made aware of the significance of their conduct and the professional means by which problematic conduct could be modified, only a fifth of the group who perceived unmet treatment needs said or strongly implied that lack of factual information was the major barrier, as in these comments:

> There are a lot of people that should go, but they won't go. (P) They don't know that those people can help them any. (C) If people don't understand that there is anything wrong with them, they won't do anything about getting help.
>
> Because they just don't think that they need one. (P) No other reason.
>
> They don't know about these doctors or where to find them.

The next step up in complexity of the factors seen as operating to deter people from seeking psychiatric treatment was the view that, even if people had sufficient information available to them to be able to judge when they needed psychiatric assistance, they would not be able to act on their knowledge because of the high cost of psychiatric treatment and, occasionally, other objective difficulties like the shortage of trained psychiatrists. All told, a third of the group who saw any problem of unmet therapeutic needs mentioned the objective, external barriers of lack of money and facilities, but, as with lack of factual information, these were much less frequently regarded as the whole story. Only about a seventh felt that the heart of the problem resided in the economic sphere, as with these explanations:

> They are not able to see one. If they could and knew why to go, they would go to see a psychiatrist.
>
> Financial reasons. (C) I think the average person would, if he had the money--unless he was in fear of being told he was nuts, but I doubt that.

As the preceding quotation already implies, there was a frequent feeling that treatment needs went unserved because of emotional resistance to psychiatry, at least on the part of those who needed treatment, if not the entire population. For two-thirds of those who thought there were people in need of treatment who were not receiving it, the situation was one which could not be met either by supplying factual information about the symptoms and treatment of emotional disorders or by overcoming economic barriers. Rather, these people felt that information would be rejected and treatment avoided because of the attitudes with which emotional problems and their psychiatric management were regarded. This position was, perhaps, summed up most fully by a man who said, "They don't realize they need help; they couldn't afford to

go, if they did; they wouldn't go, if they could; and, after they did go, they wouldn't believe what he said."

More generally speaking, there were essentially three recurrent themes in this analysis of the nature of popular emotional resistance to psychiatry. First, these people said, individuals who needed treatment had a positive unwillingness to perceive symptoms of emotional disorder in themselves, no matter what information was made available to them. Second, this reluctance to define one's self as an emotional or psychiatric problem was accounted for in terms of the importance to the individual of maintaining and defending his image of himself. Here, people pointed out that psychiatry was popularly associated with insanity or suspect in other ways, and no one could be expected to take steps on his own initiative to define himself publicly as insane or to acquire the stigmas that went with it. Or, they said, people do not always want to know and reveal the truth about themselves; there are some thing about themselves that they would just as soon not know, especially if there was any danger of discovering that something was seriously wrong and, perhaps, required commitment to a mental hospital; others which they would be ashamed and embarrassed to reveal even to a therapist; and still others which, if recognized and revealed, might require a giving up of gratifications derived from the symptomatic behavior. Finally, people felt, the need to defend one's self-conception against these threats posed by psychiatry might lead to or simply be expressed as a positive intellectual opposition to psychiatry--to distrust of or disbelief in the methods and theories of psychiatry: The various themes in this discussion of emotional resistance to psychiatry are exemplified in the following remarks:

> She says she can't afford it, but most of all she doesn't think she needs help and no one can tell her different.
>
> They don't want to admit there's something wrong. (C) They won't face it themselves, let alone talking about it to someone else.
>
> I think there still remains a stigma in the minds of some people that, if they were to go to a psychiatrist, they are admitting a kind of insanity. (C) They don't like that and maybe they're afraid of what their friends would think, so they procrastinate, perhaps thinking they can work it out themselves in time.
>
> They have a notion it's demeaning to go to psychiatrists.
>
> Some people are ashamed of the truth and don't have the ability to be honest. (C) Honest with themselves--they possibly are hiding from themselves by false pride or an inflated ego.

> They just don't know one, I guess--I don't think there are too many. But then, too, they think they'll find out something about themselves that they don't want to know. (C) It may be a fear that he would put them in an institution.
>
> Yes, I believe a lot of divorced women with children. (P) They are afraid to go and find out they are wrong. They know they aren't doing right, byt they don't want anyone to tell them so. (C) They still want to have a fling instead of responsibilities and want their freedom after they've started a problem.
>
> They think psychiatrists are a little goofy--I guess maybe because of the cartoons in the newspapers and the talk you hear. (C) When they do see a psychiatrist, they come out and say "that guy is crazier than I am." (C) They probably don't trust the guy because they are afraid he is going to find out something, I guess.
>
> Most people scoff at them. (C) They don't have any faith in psychiatry and don't believe it would help them.

However penetrating these comments on public attitudes toward psychiatry may appear, it must be borne in mind that they expressed the views of a relatively sophisticated minority of the American public; it was, after all, less than a fifth (18 per cent) of the entire adult population who believed that there was any emotionally-determined avoidance of needed psychiatric treatment. Yet, it cannot be expected that the kind of passive resistance to psychiatry which appears to have characterized the majority of the American public could ever receive any direct expression. In the nature of the case, popular attitudes were, at best, oblique: the typical position was a bland assumption of absence of need for psychiatry rather than a frontal attack on the field. Whatever hostility or resistance might be suspected to lie behind this facade of reasonable indifference, it was generally not verbalized, if, indeed, it was consciously experienced. While the inference of a general passive opposition to psychiatry on the grounds put forward by the sophisticated minority seems thoroughly justified by the totality of the data of this study, all that can be said with certainty, on the basis of direct and immediate evidence, is that there was a notable popular disinclination to relate psychiatry to the problems of ordinary people.

And, certainly, people were even less inclined to see themselves as subjects for psychiatry than they were to discover psychiatric problems in their friends and acquaintances. The question of whether they personally

would want to see a psychiatrist presented itself to most people more as an opportunity to assert or affirm their normalcy than as an occasion to express their views on psychiatry. Thus, the most frequent response (36 per cent) was a flat and simple denial of need, an apparently completely pragmatic rejection of psychiatry for themselves as not wanted because not needed. (See Table 9-7.) Next most frequent (25 per cent) was an idential denial, coupled with an assertion of hypothetical willingness to consult a psychiatrist, if appropriate--now contrary-to-fact--situations should ever arise.[8a] So, three-fifths of the public dealt with the subject of personal interest in seeing psychiatrists by asserting their own mental health: they were "normal," had "no need," but would certainly "not hesitate to see one if there were ever any need," or "if their family physician felt it was indicated," and so on. At the same time, there was often a flavor of defensive hostility in the way these answers were put, almost as if to ask a person if he <u>wanted</u> to see a psychiatrist was to suggest that he <u>needed</u> to, an implication which, in turn, required an immediate denial. For instance:

> Why should I? There's nothing wrong with me.
>
> I don't feel that I need to see one.
>
> I'm all right. I'm not such a problem that I should see a psychiatrist.
>
> I just don't think I have any serious problems.
>
> I wouldn't mind seeing one if I needed to, but I don't have any need to.
>
> No, but if I felt there was something wrong with me, I'd go right away.

[8a] Answers of this type usually contained the same sort of ambiguity already discussed under the heading of "The Place of Psychiatry." The hypothetical circumstances under which these people said they would consult psychiatrists was furmulated as:

Without delay	4%
With personal strain	7
With external effects	1
In due course	3
If "needed," not further specified	10
Total contingently willing.	25%

Some of these contingencies were unquestionably added to express genuine favorableness toward psychiatry, others served primarily to emphasize the denial of need and the two cannot be reliably distinguished.

Once again, then, the dominant popular tendency was to subordinate the question of psychiatry to the question of the presence or absence of mental illness, with psychiatry indicated, if mental illness were present; irrelevant, if it were not.

Aside from this basic tendency to minimize the relevance of psychiatry for themselves as for others, there were 15 per cent who saw psychiatry as relevant to themselves and expressed some degree of interest in seeing a psychiatrist. The group was made up of nine per cent who had some current interest in obtaining therapy for a variety of personal problems, most of which centered around impaired emotional tone--anxiety, tension, depression, frustration, etc;[9] one per cent who had once desired--and generally obtained--therapy for similar problems, but who felt they had no present need for further psychiatric care; three per cent who thought that a general check-up on their mental health through a single visit to a psychiatrist would be a wise

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[9] The exact symptoms presented by respondents with some interest in therapy for themselves were:

	Proportion of All Respondents	Proportion of Respondents Interested in Therapy
Primary psychotic categories		
Impaired cognitive control (hallucinations, delusions, break with reality, etc.)	*	3
Violence	*	*
Ambiguous categories		
Deleterious consequences for lives of others	*	5
Objective disruptions of person's own life (impaired functioning, inability to function)	*	1
Deviant or abnormal behavior, general and unspecified	*	*
Primarily neurotic categories		
Impaired emotional tone (anxious, tense, irritable, conflictful, depressed, frustrated, dissatisfied, etc.)	5	61
Impaired health (insomnia, fatigue, psychosomatic disorders, etc.)	1	17
Impaired interpersonal relations (marital conflict, parent-child difficulties, etc.)	2	19
Not reported	1	12
Total per cent	9	118
Most severe category mentioned		
Psychotic	*	3
Ambiguous	1	6
Neurotic	7	79
None	1	12
Total per cent	9	100

The classification of symptoms used here is the same as that presented in

precaution to take, even though they had no need for treatment; and two per cent who were interested in seeing a psychiatrist as a way of learning more about the profession and the problems it dealt with. The various kinds of interest were expressed about as follows:

> Well, just because I feel not completely on the beam. (C) I think I have an anxiety neurosis.
>
> Sometimes I've thought about it, but I don't think I'm bad off about it yet. I've been thinking of seeing one about my temper. (C) That's about all I was thinking about--I don't get real violent, but I do lose my temper a lot.
>
> I went to one about my problems with my first wife, and I'd go again if I needed one again.
>
> Yes, it wouldn't do me any harm. (C) I think I'm a normally adjusted person, but I'd like to see if he would agree with me--a general check-up just to satisfy yourself.
>
> Yes, for the experience, just to see the way the man works. (C) No, nothing else.

At the opposite pole, a slightly larger minority--20 per cent--were expressly unfavorable to the idea of consulting psychiatrists themselves, for reasons going beyond simple lack of need for such services. These opponents of psychiatric treatment were, presumably, at least part of the group the sophisticated minority was talking about in saying that they knew people who failed to obtain needed psychiatric care for reasons of emotional resistance or opposition, so it is interesting to note the extent to which the opponents of psychiatry themselves confirmed the analysis of the basis of their hostility advanced by the other group.[10]

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[10]These two groups are, of course, for the most part mutually exclusive. Only two per cent of the total population expressed both a belief that some of the people they knew emotionally resisted needed psychiatric therapy and opposition to consulting psychiatrists themselves, so, roughly, about a tenth of each group was contained in the other, while nine-tenths of each group were independent of the other:

Did not know other people emotionally opposed to needed therapy	
Not expressly opposed to therapy for self	64%
Expressly opposed to therapy for self	18
Knew other people emotionally opposed to needed therapy	
Not expressly opposed to therapy for self	16
Expressly opposed to therapy for self	2
Total	100%

The comparisons between these two groups discussed in the text and reported in Table 9-8 are not at all modified when the small overlapping segment is removed from consideration.

The group talking about other people's opposition to psychiatry had, it will be recalled, stressed its defensive nature: to them, it was primarily a matter of people warding off either unacceptable insights or being forced to see themselves in an unfavorable light, and only secondarily any justified or unjustified direct criticism of the validity or efficacy of psychiatry, with, in fact, the secondary theme often regarded as an intellectualized rationalization of the primary resistance. This was, of course, a comfortable mode of analysis for people talking about persons they regarded as less enlightened than themselves, but it was not, on the face of it, a formulation calculated to be equally acceptable to the people being discussed. It was to be expected that the opponents of psychiatric therapy for themselves were a good deal more likely to attribute their opposition squarely to what they saw as the shortcomings of the field--psychiatry was unsound at base, or an unnecessary refinement or, if it had some validity, still open to question and not firmly established as a reputable specialty:

> Oh, no! I'd be worse when I came out than when I went in. (C) They ask you comical questions and make you silly. Some fellow had to sit down while the psychiatrist walked around the room and then came up and said "Boo" to scare him. I can't see them doing anything.
>
> I don't see any reason for ever needing one. Your doctor can do just as much.
>
> I'd be afraid to. (C) Some of them do good work, but there are a lot of quacks in that just in it for the money and they can do you a lot of harm.

Much more remarkable, however, is the fact that the opponents based their objections to psychiatric therapy on the defensive lines centering around protecting a particular image of themselves just as often as they attacked psychiatry--they preferred to think of themselves as rational, self-reliant people capable of handling their own problems, so admitting a need for therapy carried with it internal as well as external stigmatization, or therapy appeared in other ways to be an assault on their personal integrity. (See Table 9-8.):

> I just feel I could cure myself better than anyone else could. (C) A person knows their own problems and then it's up to him to help himself.
>
> They're for crazy people and I'm not that bad yet. I know what I'm doing, so what would I do with a psychiatrist?

> I wouldn't want to go to one of them at all. (C) I don't know, I just wouldn't want to, that's all. (C) You feel sort of ashamed, that's all I can say.

Although there were, then, substantial differences in the explanations advanced by the two groups, the fact that roughly half the opponents of personal psychiatric care themselves expressed the kind of self-protecting motives for their stand as were imputed to them by the majority of the proponents of psychiatry serves to suggest the validity of the latter's interpretation.

As might be inferred from these data, personal interest in or opposition to psychiatry--which can, after all, be regarded as the counterpart on the personal level of perception or lack of perception of the relevance of psychiatry for others--was related to general orientations toward psychiatry in much the same fashion as the other indicator of relevance. As before, people with a background of interest in and contact with psychiatry were much more likely to indicate interest of whatever kind in seeing a psychiatrist personally than were people with no prior experience with psychiatry. As shown in Table 9-7, the difference was very marked, with 30 per cent of those dubbed most involved in psychiatric intellectual currents but only four per cent of those least involved expressing any kind of interest in a personal psychiatric consultation. Just as before, also, these differences are markedly increased if further criteria of psychiatric involvement or knowledgeability are added: For example, among the group defined as being most involved, 42 per cent of those who both consistently used the term "mental illness" to include non-psychotic syndromes and consistently applied this usage to the concrete examples said they would like to see a psychiatrist, as over against 27 per cent of those with less consistent usage. Correspondingly, none of the former sub-group, but 17 per cent of the latter were to some degree opposed to psychiatric consultation for themselves. At the other extreme of least involvement with psychiatry, the respective percentages of interest were 20 per cent vs. 3 per cent, and of opposition, 20 per cent vs. 32 per cent.

Both sets of data--perceptions of unmet needs for psychiatric care in one's own social circle and attitudes toward consulting a psychiatrist oneself--thus consistently indicate that acceptance of psychiatry as relevant

to the everyday life of people like themselves was concentrated in that segment of the population whose experience and interests had led to orientations toward the nature, sources and control of human behavior most consonant with the theoretical positions of psychiatry. For the bulk of the population, however, the profession of psychiatry occupied a good deal more anomolous status, not easily categorized as either favorable or unfavorable. The final section of this chapter attempts a more precise characterization of the thinking of the majority.

In Sum: Attitudes toward Psychiatry

From a consideration of all of the information contained in the interviews, attitudes toward psychiatry can be summarized about as follows:

3% . . . were completely opposed to psychiatry

7% . . . were strongly opposed to psychiatry

19% . . . were opposed to psychiatry, but to lesser or to indeterminate degrees

69% . . . were not expressly critical of psychiatru, but

- 39% . . . appeared unaware of, indifferent to, or implicitly rejecting of psychiatry, while
- 30% . . . appeared implicitly accepting of psychiatry

2% . . . were avowedly approving of or even enthusiastic about psychiatry

The small group classified as "completely opposed" to psychiatry rejected psychiatry out-of-hand, both for themselves and for others, and attacked the validity of the basic theories and practices of psychiatry.[11] Typical of this extreme attitude were the following comments of two respondents, the first of whom made no reference to psychiatry until he was questioned about it; the other, a woman who volunteered her hostility early in the interview:[12]

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[11] The detail of people's comments about psychiatry is presented in Table 9-9. Table 9-10 indicates the relationship of each aspect of the discussion of psychiatry to these summary classifications.

[12] Since psychiatry was discussed at a number of different points in the interview, all relevant remarks in a single interview are quoted. To make the sequence intelligible both the question being answered and its number in the sequence of the interview are quoted in parentheses, along with the usual indications of interviewer probes and requests for clarification.

(Q. 29. As you see it, how serious a problem should a person have before he goes to see a psychiatrist?) I don't know. (P) I don't think I'd have to go to anybody to tell me I was crazy, hold my hand and talk to me for twenty dollars an hour. A person does that, they really are crazy. If they didn't have any more sense than to go, they ought to be put in a nut house. (Q. 30. As far as you know, how does a psychiatrist go about helping the people who come to him?) I think it's hypnotism to a certain extent. (C) They've got to help themselves; their own help is better than that. (P) I read something about it: they hold your hand, talk to you, let you do the talking, till you've so many things piled up on your mind that you should forget, that your mind is loaded up with everything that ever happened to you in your life. (Q. 33. Do you think you would want to see a psychiatrist?) No! I've got no use for them.

(Q. 9. The Story of "George Brown"--What do you think makes him act this way?) Psychiatrists say something in your childhood causes that, but I don't believe it. (P) I don't know what makes him like that. (Q. 29. As you see it, how serious a problem should a person have before he goes to see a psychiattist?) I wouldn't know, but I don't think I'd go to one at all. (Why?) I don't have much confidence in them. (Q. 33. Do you think you would want to see a psychiatrist?) I don't believe in them. (Why?) I think they just stir up more trouble.

The group classified as "strongly opposed" was almost equally critical of the theory and practice of psychiatry, but stopped short of total repudiation: either they were unalterably opposed to psychiatric care for themselves, but conceded other people might benefit from it; or they reluctantly viewed psychiatry as an unpalatable remedy which might have to be tried as a last resort. For instance:

(Q. 8. The Story of "Betty Smith."--Why do you say that she does not have a mental illness?) She's just maladjusted, and her parents could do more to help her than a psychiatrist. (Q. 16. Who could help them /people who have these less severe conditions/ with their problems?) Someone close to them, a friend. (Anyone else?) Probably some could be helped by psychiatry. I don't have too much faith in psychiatry myself. (Why?) I don't think psychiatrists can help much because they are more interested in the cause rather than the cure. I've seen it happen. Psychiatrists will try to find out why alcoholics drink. It's more important to eliminate the disease. Who cares what caused it? (Q. 18. What do you suppose you would do if you were worried about someone in your family who was not acting like himself?) Try to find the cause of it myself and then try to clear it up. (How?) I'd try to find an interest for them, find something new--take up a hobby, games, sports, reading, anything. (Suppose that didn't work, what would you do next?) If that didn't work, I'd try to have a

relative or a friend for whom they had respect talk to them. As a very last resort, I'd try psychiatry. (Q. 21. What could be done /beforehand to keep a person from losing his mind/?) At the very first sign of illness, try to direct their thoughts in new channels and make them happy. It must be something that makes them unhappy that causes it. (What else could be done?) Psychiatric care after other attempts to help have failed. (Q. 29. As you see it, how serious a problem should a person have before he goes to see a psychiatrist?) Well, when it's really affecting his peace of mind, when he and his relatives can't seem to help. I don't have much faith in psychiatry. It's one branch of medicine that's far behind. They don't have competent teachers of psychiatry. Most psychiatrists are general practitioners who are not really capable; they've taken a course or two and set themselves up as psychiatrists. (Q. 30. As far as you know, how does a psychiatrist go about helping the people who come to him?) They first try to put you at ease, gain your confidence. Then they try, through going back to your childhood, to find your disease. Then they try to eliminate the cause and, through that, the disease. In most cases, it doesn't work. Most cases are self-inflicted; it's an escape, who cares about the cause. It's more important to find a new way of life for these people. (Q. 31. Why didn't the treatment help /a close friend who was seeing a psychiatrist/?) I think the psychiatrist wasn't capable and the psychiatrist goes about it in the wrong way. I know an alcoholic who was told by the psychiatrist that he wasn't an alcoholic and could drink as much as he wanted. That was all he wanted to hear. He ended up in a mental hospital. He's out of the hospital now, but is still an alcoholic. There is use for psychiatry, but as it's practiced today it does more harm than good. (Q. 33. Do you think you would want to see a psychiatrist?) Only as a last resort. They aren't capable, and, secondly, they charge too much money.

The larger group with less well-defined opposition or resistance to psychiatry consisted of people who spoke of psychiatry favorably or neutrally in a number of contexts, but also indicated some reluctance about it. Their position did not so much involve basic opposition to the very premises of psychiatry as doubts and hesitancies, on the one hand, and resistance to its implications for their conceptions of self-sufficient individuality, on the other. Quite typically they were people who thought of psychiatry as having dubious respectability, or people who evaluated self reliance highly and saw resort to psychiatry as a sign of personal weakness, or people who associated psychiatry with insanity and treated the possibility of their wanting psychiatric assistance as tantamount to questioning their sanity. Probably their opposition to psychiatry was often not much greater than the kind of resistance psychiatrists report is present in practically every patient, but they did

verbalize it in the interview and are, accordingly, classified separately. Here, for example, are three quite typical positions:

> (Q. 29. As you see it, how serious a problem should a person have before he goes to see a psychiatrist?) They shouldn't wait, if they feel there is anything wrong. (Why?) To prevent further developments. (Q. 30. As far as you know, how does a psychiatrist go about helping the people who come to him?) I don't know. (P) They ask about their childhood to find out habits of living and to discover jealousy or such. (Then?) I don't know what he does then. (Q. 31. Why didn't the treatment help /an acquaintance who saw a psychiatrist/?) I don't think there was anything wrong to begin with. (C) She went because her husband wanted her to, and the doctor said she was saner than her husband. (Q. 33. Do you think <u>you</u> would want to see a psychiatrist?) No, I'd go to a higher power. (Why?) A psychiatrist can't help, the person must help himself.

> (Q. 16. Who could help them /people who have these less severe nervous conditions/ with their problems?) A doctor--either a doctor or a psychiatrist. (What could they do that would help?) They'd find out what was bothering him and talk to him. (Q. 18. What do you suppose you would do if you were worried about someone in your family who was not acting like himself?) Go to a doctor, take him to our own doctor first. (Then?) Do what the doctor said, maybe see a psychiatrist. (Q. 29. As you see it, how serious a problem should a person have before he goes to see a psychiatrist?) He should go right away to get cured. (Q. 30. As far as you know, how does a psychiatrist go about helping the people who come to him?) He talks to them to find out what's ailing them. (Then?) Then he tries to cure them. (How?) I don't know how. (Q. 33. Do you think <u>you</u> would want to see a psychiatrist?) No, I'm not crazy yet--that's for crazy people, not people like me.

> (Q. 16. Who could help them /people who have these less severe nervous conditions/ with their problems?) See a doctor--a medical doctor can help, but not a psychiatrist. (C) Most of them are no good, a good one might help. (Q. 18. What do you suppose you would do if you were worried about someone in your family who was not acting like himself?) Have a good medical doctor give him a good checking and then follow his advice. (Then?) See a psychiatrist that a physician would recommend. (C) I know so little about psychiatrists--some may be good, but I don't know how you'd find out. (Q. 29. As you see it, how serious a problem should a person have before he goes to see a psychiatrist?) As soon as it is out of the hands of a family physician. (C) The feeling of seeing a psychiatrist makes a person think he is mentally going cuckoo and may send him crazy sooner. (Q. 30. As far as you know, how does a psychiatrist go about helping the people who come to him?) I never had any experience. (P) I saw a picture where a man talked with a psychiatrist. The psychiatrist brought out that the patient thought his parents loved his brother more as a child. He carried this grudge to manhood, when he decided to kill the hated brother. The psychiatrist made the patient see his error. (Q. 33. Do you think <u>you</u> would want to see a psychiatrist?) No, I have no immediate problem and couldn't afford to pay one if I needed him.

At the other extreme were the two per cent who explicitly expressed approval of or even enthusiasm for the work of psychiatry, as with the woman who said:

(Q. 16. Who could help them /people who have these less severe nervous conditions/ with their problems?) Psychiatrists are wonderful, but how could a person like me afford to go to one? (What could they do that would help?) They could teach you to take care of yourself and show you how to think healthy. He'd also find out something way back in the past that is bothering you, and he'd teach you to relax. I think they could help you with your home problems, too--give you someone you could talk to and let your hair down. (Q. 18. What do you suppose you would do if you were worried about someone in your family who was not acting like himself?) First, I'd take them to a doctor. Then, if they were all right physically, I'd see a psychiatrist if I could afford it. (C) I couldn't afford a psychiatrist, so I'd talk it over with my doctor and see if he could suggest something else. (Q. 29. As you see it, how serious a problem should a person have before he goes to see a psychiatrist?) As soon as you had any sign of nervousness and your doctor found out there wasn't anything physical. (C) Well, in my case, it's an awful tightness in the throat and dizzy spells and worrying all the time--I mean when anyone gets to be like that /he should go to a psychiatrist/. He could help them to get over it. (Q. 32. Why do you suppose they /people who you think would be helped if they'd see a psychiatrist/ don't see one?) I haven't got the money, I certainly would love to see one. I have a friend and she needs the same help, but she can't afford it either. (P) There isn't any other reason.

Over two-thirds of the American population, however, expressed neither the varying degrees of hostility of the first three groups nor the unequivocal positiveness of this last one. Instead, they generally said very little about psychiatry, and what little they did say was couched in primarily factual terms. Although there is relatively little information to go on,[13] it is possible to divide this majority group into two, 30 per cent relatively favorably oriented toward psychiatry, and 39 per cent less favorably disposed. That is to say, the questions which directly or indirectly elicited respondes about psychiatry were of essentially two kinds. There were, first, questions which tapped primarily formal, impersonal knowledge--such questions as those dealing with what sources of help should be utilized in treating

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[13] The failure to ask any directly evaluative questions about psychiatry may be looked upon as one of the major omissions of this study. At the time it was planned, however, it seemed impossible that people could answer so many questions about psychiatry--and particularly the question about consulting psychiatrists themselves--without expressing their feelings. In one sense, the very absence of unambiguous comment, whether positive or negative, reinforces the impression of the remote character of psychiatry, which has been a recurrent theme of this chapter.

or preventing nervous conditions and psychoses (Questions 16A(2), 17A, 19A, 21A) or in coping with a hypothetical family crisis (Questions 18A and B), and those concerned with the proper point at which to consult psychiatrists and how a psychiatrist would proceed at this point (Questions 29 and 30). All of these questions are alike in calling for abstract theoretical discussion of procedures in hypothetical or imaginary terms. While some answers to these questions--like saying that a person with a nervous condition should see a psychiatrist at the very first sign of illness--might appear superficially favorable to psychiatry, the fact was that answers of this sort depended more on formal knowledge than on genuine feeling. That is, people who, in answer to the direct question on how a psychiatrist proceeds, proved to have some specific information about psychiatric therapy, tended to volunteer psychiatry as an appropriate source of aid in the treatment and prevention of mental illness irrespective of their own feelings about psychiatry:

	Per cent Volunteering Psychiatric Persons as Source of Aid in Treatment or Prevention
Had some information about psychiatric procedures	
No hostility expressed	91
Some hostility expressed	80
Had no information	
No hostility expressed	54
Some hostility expressed	39

In the absence of explicit criticism or endorsement of psychiatry, these volunteered answers in terms of psychiatry were actually most ambiguous so far as attitudes toward psychiatry were concerned. They indicated, at best, that the individuals making them had some knowledge of conventional definitions of psychiatry's functions and area of competence, but they did not offer much guidance to their evaluations of psychiatry.

There were, on the other hand, three questions where answers seemingly favorable to psychiatry strongly implied favorable evaluations as well as demonstrations of knowledge. These were the questions of whether a person known by the respondent to have been treated by a psychiatrist was helped by the treatment (Question 31B), whether the respondent knew anyone, not in

treatment, who would benefit from psychiatric care (Question 32), and whether the respondent had any current interest in seeing a psychiatrist himself for whatever reason (Question 33A). As might be expected, these personal salience questions were also related to knowledge about psychiatry, since it requires some familiarity with a topic to see any personal relevance in it. Nevertheless, these questions distinguished far more sharply between the avowedly hostile and the explicitly friendly than did the earlier type of information question:

	Explicitly Hostile	Non-Evaluative	Explicitly Approving
Proportion spontaneously referring to psychiatric persons in at least one information question	62	77	92
Proportion answering favorably to psychiatry in at least one salience question	29	44	78

On the face of it, positive answers to the three personalized questions all have in common a recognition and acceptance of the legitimacy and applicability of psychiatry close-at-hand, in everyday life, as contrasted with the more impersonal awareness demonstrated by the earlier questions. At the same time, they were, in fact, better predictors of attitudes toward psychiatry than were the measures of abstract acceptance of psychiatry. Consequently, in the absence of any more definitive comments about psychiatry, people who gave an answer implying personalized acceptance of psychiatry to any one of the latter three questions are classified as "implicitly accepting" psychiatry. People who consistently gave answers denying that psychiatry had anything to do with their lives to all three questions--that is, they knew no one who had been helped by psychiatry, knew no one who could be helped by psychiatry, and had no interest in seeing a psychiatrist themselves--are classified as "implicitly rejecting" psychiatry, at least so far as any personal significance is concerned, regardless of whether or not they had made academic mention of psychiatry in the abstract to the earlier questions.[14] Since both of these positions are characterized primarily by an absence of free and full comment on psychiatry, it is difficult

[14]While this classifying procedure makes sense conceptually and is, in any case, the best that can be done with the rather thin data at hand, it is reassuring to note (in Table 9-10) that the answers of those classified as "implicitly accepting" to every question bearing directly or indirectly on attitudes toward psychiatry resemble most closely those of people classified as explicitly approving or enthusiastic. The group classified as "implicitly rejecting" most closely approached the groups characterized by opposition to psychiatry, especially the group of lesser or indeterminant degrees of opposition.

to illustrate satisfactorily either the 39 per cent who implicitly rejected psychiatry to somewhere outside the purview of their lives or the 30 per cent who implicitly accepted it. The following complete extracts from one interview for each position may indicate somewhat the academic and unreal quality psychiatry assumed when the implicitly rejecting discussed it, as over against the more realistic approach of the implicitly accepting:

> Implicit Rejection (Q. 16. Who could help them /people who have these less serious nervous conditions/ with their problems?) Doctors. (C) Doctors who specialize in mental illness. They study nervous systems, and they have special medicines for those conditions--A specialist in mental illness. (What do you think they could do that would help?) They specialize in taking care of those kind of mental patients. (P) I don't know except for medicine. (Q. 18. What do you suppose you would do if you were worried about someone in your family who was not acting like himself?) I'd take him to a doctor--a specialist for nerves--as soon as I noticed him. (Q. 29. As you see it, how serious a problem should a person have before he goes to see a psychiatrist?) The sooner the better, as soon as they see signs that something is wrong, take them right away. (Signs?) When they start talking to themselves or they do something queer. (Q. 30. As far as you know, how does a psychiatrist go about helping the people who come to him?) He finds the cause of the sickness, starts asking questions to find the cause--if it's a real sickness or a family inheritance or what the cause is. (After he finds this out, what does he do?) If he has the right way and medicine, he'd start right away to use the medicine. (Anything else?) I don't know what else. (Q. 31. Have you ever known anyone who was seeing a psychiatrist, without being in a mental hospital, or anyone who was going to a guidance or mental hygiene clinic?) No. (Q. 32. Do you know any people who you think would be helped if they'd see a psychiatrist?) No. (Q. 33. Do you think you would want to see a psychiatrist?) No. Of course, if I ever feel something wrong in me, I'd sure go right away.

> Implicit Acceptance (Q. 16. Who could help them /people who have these less severe nervous conditions/ with their problems?) A psychiatrist. (What do you think a psychiatrist could do that would help?) He could build up a relationship between himself and the patient and discover the reason for their nervous condition. Then he'd prescribe treatment such as rest or a sedative and give him the correct mental attitude. (Q. 18. What do you suppose you would do if you were worried about someone in your family who was not acting like himself?) I would take them straight to a psychiatrist. (Q. 29. As you see it, how serious a problem should a person have before he goes to see a psychiatrist?) I don't think it should be very serious. They should go at the first indication of anything

being wrong. (Why?) This will give them a good chance to nip it in the bud and not let it get aggravated. (Q. 30. As far as you know, how does a psychiatrist go about helping the people who come to him?) I practically covered that when I answered an earlier question, so I'll just sum it up: He'd get their confidence and establish a rapport and thereby determine the cause. Then he'd prescribe proper treatment such as rest, sedatives or therapy. (Q. 31B. Do you think this person /an acquaintance who is seeing a psychiatrist/ is really being helped?) No. (Why not?) Well, really, she hasn't been going long enough yet to tell whether it will help. (Q. 32. Do you know any other people who you think would be helped if they'd see a psychiatrist?) Yes. (Why do you suppose they don't see one?) Because they don't think they need it, and they probably can't afford it either. Psychiatrists are very expensive. (Q. 33. Do you think you would want to see a psychiatrist?) No. (Why not?) Because I have no major problems and, while I may not be bright, I certainly feel that I'm completely stable mentally.

Implications and Conclusions

The situation of psychiatry in American popular opinion was, then, primarily one of rejection, if not one of outright hostility. At least two-thirds of the adult public drew away from psychiatry, sometimes with avowed disapproval but, more often, by default--through a disjunction of their theoretical knowledge and the concrete world in which real life was lived--probably without any awareness that the sum of their disparate attitudes was, in fact, a negation of psychiatry in practice.

With this conclusion, we have, in a way, come full circle, for here once again, is the paradox from which we began: Just as broadly inclusive definitions of mental illness were frequently acquired from the informational media, but proved singularly incongruent with and, in practice, inapplicable to, human behavior as people experienced it, so psychiatry--the ultimate source of this inappropriate usage--was also known in a formal, theoretical way, but usually turned out to be equally irrelevant to daily life. Psychiatry, like its works, remained outside the main stream of popular thinking, distantly perceived, formally saluted upon ritual occasions, but essentially a stray bit of esoterica standing apart from and alien to the fundamental system of ideas about human behavior.

What it comes down to is that attitudes toward psychiatry cannot actually be separated from attitudes toward mental illness. Rather, they

were merely another aspect of the same basic dilemma that has been the central concern of this volume; viz., the encounter between two basically incompatible modes of thought about human behavior and the compromises by which reconciliation is attempted or recognition avoided.

So many data can be ranged to demonstrate the validity of this conclusion that the problem becomes one of selection and synthesis. To put it most summarily, however, every viewpoint implying acceptance of a psychiatric approach to human behavior correlates positively with attitudes toward psychiatry and every index of subscription to more traditional views of human conduct correlates negatively. These relationships are all substantial and hold true, no matter what differences in background are taken into account. Even more impressively, these relationships, summarized in Table 9-12, are not as tautologically self-evident as this statement might imply, but instead involve factors which, at first glance, might well appear to be quite irrelevant to people's attitudes toward psychiatry.

So, the group most likely to be hostile to and least likely to be accepting of psychiatry were those people whose ideas and feelings were organized around an image of mental illness as an overwhelming threat. These were the people who tended to define mental illness as cognitive or control deviancy, and, accordingly to limit mental illness to psychosis and, usually, to those forms of psychosis which exhibit extremes of irrationality, violence and loss of self-control. They were people who thought of mental illness as an irreparable rent in the individual's system of controls if not an incurable disease, people who regarded the mentally ill as dangerous to them and who feared contact even with persons who had presumably recovered from at least the acute phases of their illness. By the same token, they were people who valued rational self-control so highly that its loss was the ultimate, unacceptable indignity and who regarded almost all human behavior--except their fearful counterimage of mental illness--as falling within the realm of the easily self-controlable. In short, then, it was a group of people for whom the measure of their overt hostility to or passive avoidance of psychiatry was simply the weight of their need to ward off from themselves the threats implicit for them in the very term of mental illness.

Conversely, the group most likely to accept psychiatry at a personal level were those people whose ideas and feelings about human behavior derived in large part from the theoretical systems of dynamic psychology

rather than exclusively from the rational-moral considerations underlying the previous position. They were, then, the people who identified mental illness with deviancy of emotional response and who, therefore, included a broad range of disorders within the category of mental illness. They were people who thought of mental illness as deviant response patterns whose origins were traceable to much the same--and, primarily, psychodynamic--factors as more normal emotional patterns. With this more determinist approach to human behavior, they were, as a result, people who were less insistent on the significance of rational self-control whether as an effective means of modifying human behavior or as the all-important human trait whose supremacy must not be challenged by confrontation with mental illness. But, if they were less optimistic about the ease with which behavior, in general, could be modified by rational self-control or by the rational appeals of others--lay or professional, they were, by the same token, more optimistic than the traditionalists about the curability of psychosis, first, because they did not view mental illness as so extreme a departure from the norm as rationalists were forced to by the logic of their own position, and, second, because their interpretive scheme for human behavior did not so easily conclude that people unamenable to rational appeals were ipso facto inaccessible to influence and modification. All in all, then, they were people in whom fears of mental illness, the mentally-ill, and the formerly mentally-ill were all minimized by starting from a different set of basic premises about human behavior. In sum, it was a group of people for whom acceptance of psychiatry was simply another symbol of their acceptance of a view of human behavior which recognized the role of irrational and non-rational elements in all human behavior and which, in so doing, moderated equally the threat to self-conceptions that the more flagrant manifestations of irrationality--exhibited in some forms of mental illness--otherwise posed and the consequent recoil both from mental illness and from its professional custodians.

While the two polar positions just sketched help to clarify the complex conceptual differences underlying attitudes toward the profession of psychiatry, they must be thought of as primarily heuristic devices. That is, in the pure and extreme forms just stated, neither orientation existed to any appreciable extent in the American population. Rather, almost everyone's thinking contained elements drawn from both systems of thought,

although--as the majority's rejection of psychiatry implies- the historically-earlier position was still the more dominant one. To represent the actual position of most people's thinking, somewhere along a continuum between these two extremes, it is possible, however, to fall back upon rough indices of the extent of agreement with each position.

Briefly, the degree to which people adhered to the approach to human behavior characteristic of modern psychological thinking is indexed by assigning one point for each of the following views:[15]

PREMISES ABOUT HUMAN BEHAVIOR

- --Explanations of human behavior stress psychodynamics
- --Little or no stress is given to rational self-control as a means of modifying problematic behavior.

DEFINITIONAL CONCLUSIONS ABOUT MENTAL ILLNESS

- --Mental illness is consistently defined as including non-psychotic disorders
- --Mental illness is descriptively characterized as emotional-functional deviancy
- --The concrete examples typifying both psychosis ("Frank Jones" and "Betty Smith") and anxiety neurosis ("George Brown") are perceived as mentally-ill.

CONSISTENT IMAGE OF THREATS OF MENTAL ILLNESS

- --Psychotics are regarded as generally not dangerous
- --Psychosis is regarded as generally curable
- --Recovered former patients would be treated like anyone else.

Conversely, the moral-rational approach was indexed by assigning one point to each position diametrically opposed to the foregoing, leaving "middle" positions on each item out of account for either score. Thus, the rational orientation score is a count of the number of the following views that a person expressed:

PREMISES ABOUT HUMAN BEHAVIOR

- --No reference is made to psychodynamic factors in human behavior
- --Great stress is given rational self-control

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[15]The exact detail of the scoring procedure appears in Table 9-13.

DEFINITIONAL CONCLUSIONS ABOUT MENTAL ILLNESS

--Mental illness is defined as psychosis

--Mental illness is characterized by cognitive-control deviancy

--Mental illness is typified only by the concrete example manifesting violence ("Frank Jones") or by something more extreme than any of the examples.

CONSISTENT IMAGE OF THE THREATS OF MENTAL ILLNESS

--Psychotics are thought to be dangerous

--Psychosis is regarded as incurable

--Ex-patients arouse fear and avoidance.

Given these definitions, it is now possible to say, more precisely, that the greater people's degree of psychological orientation the greater was their acceptance of the use of psychiatrists, and, contrariwise, the greater people's adherence to the rational orientation, the less they accepted psychiatry. Indeed, at the extremes, the relationship was as perfect as the earlier discussion implied: among the very few persons who gave expression to every one of the views employed to characterize the psychological approach, all accepted psychiatry; among the even fewer persons who expressed all the views typifying the rational approach, none was favorable.[16] For all degrees between, favorableness toward the profession of psychiatry consistently declined:

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[16]Only ten persons in the sample--about three-tenths of one per cent--received perfect scores on the index of psychological orientation; just half as many received full scores on the index of rational orientation. Percentages would not ordinarily be presented for so few cases and are included here only for illustrative purposes.

Net Degree of Psychological Orientation[17]	Proportion Accepting Psychiatry (among Respondents with Each Net Score)
+8	100
+7	78
+6	58
+5	53
+4	53
+3	42
+2	39
+1	33
0	33
-1	29
-2	24
-3	25
-4	20
-5	16
-6	15
-7	15
-8	0

[17]The score shown here is the difference between the psychological and rational orientation scores for each respondent. Plus scores indicate that the individual expressed more elements of the psychological orientation than of the rational orientation; minus scores, the reverse.

Dramatic though this result may appear, there remains a question of whether it does any more than summarize in another fashion the recurrent and consistent division in the thinking of the American population: every one of the views employed to index the modern psychological approach and, indeed, the favorableness toward psychiatry associated with this orientation have previously been shown to be disproportionately concentrated in the segment of the population who, by reason of education, self-exposure to information and contact with non-institutional psychiatry, constituted a kind of psychiatric avant garde. It can be said, however, that this association is by no means fortuitous. That is to say, the groups in the population whose intellectual background appeared to predispose them to favorableness toward psychiatry were, in fact, favorable precisely because they disproportionately subscribed to the psychological approach to human behavior. (See Table 9-15.) Where, despite their seemingly-appropriate intellectual background, people had not adopted this approach to behavior, they were also not inclined toward personal acceptance of psychiatry. Thus, people of similar background still differed markedly in the degree to which they accepted psychiatry, with these differences closely following differences in general orientation. Here, by way of illustrations, are the proportions accepting psychiatry among people of similar educational levels:

Net Degree of Psychological Orientation	Proportion Accepting Psychiatry, at Each Score Level, among Respondents Whose Educational Attainment Was: College	High School	Grammar School
Strongly psychological (Scores 5-8)	61	65	48
Moderately psychological (Scores 2-4)	51	44	31
Mixed (Scores, 1,0,-1) . . .	38	34	26
Moderately rational (Scores-2 to -4) . . .	24	27	19
Strongly rational (Scores-5 to -8) . . .	23	23	12

And differences like these, pointing to an independent connection between general thinking about human behavior and mental illness and attitudes toward the profession of psychiatry, persist no matter what items of background and experience are controlled.[18]

The conclusion that emerges is obvious: the public's approaches to human behavior, to mental illness, to the theoretical doctrines of psychiatry and to the practitioners of psychiatry themselves are inextricably bound up with one another. For this very reason, the dissemination of discrete, "enlightened" views about mental illness by way of mental health education--as for example, the recent insistence on two slogan-like statements: "Mental illness is an illness like any other" or Mental illness is curable"--or direct propaganda efforts to "humanize" or popularize psychiatrists as authoritative figures are foredocmed to failure. Communicating definitions of terms ("mental illness includes <u>all</u> emotional disorders, from the mildest to the most serious") or conclusions--("there is nothing about mental illness to be afraid of")--as if they were facts to people who do not share the premises about human behavior which make these assertions coherent is no different from expecting people to speak a foreign language simply from rote memorizing of vocabulary lists.

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[18] It is also apparent that a relationship between these more objective background items and attitudes toward psychiatry persists even when the variable of differences in general approach to behavior is controlled. About all that can be said is that all of the indices used are imperfect: the psychological orientation score captures some, but not all, of the psychological meaning of upper education and information access; the measure of acceptance of psychiatry is too crude to capture subtle nuances; and so on. Rough as our psychological measures are, however, they do permit identification of the factors involved in an intellectual climate favorable to psychiatry.

Despite the well-known principle of communication that people generally neither attend to nor acquire the sense of informational presentations in the mass media when the ideas presented do not mesh with their prior interests and preconceptions,[19] almost every member of the American public has, one way or another, acquired at least some of the definitions and conclusions constituting what may be called, without prejudice, the mental hygiene "line." For instance, of the six elements representing such definitions and conclusions (rather than premises about human behavior) used in the psychological orientation score, the average member of the public repeated 2.1 of them, and only 13 per cent of the public voiced none of them.[20] Nevertheless, seeming acceptance of these conclusions, in the absence of acceptance of the kind of premises about human behavior which constitute the rationale for them, did not lead to any greater acceptance of psychiatry in one's personal life. It was only when these conclusions were a logical outgrowth of a more basic general approach to human behavior which made them appropriate and intelligible, that they carried over into acceptance of psychiatry on a personal basis. Even with as rough an index of the appropriate premises as the two elements of this kind--use of psychodynamic explanations of human behavior and de-emphasis on rational self-control in the control of disturbed behavior--used in the psychological orientation

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[19] See, for example, Wilbur Schramm, "The Effects of Mass Communications: A Review," Journalism Quarterly, XXVI (1949), pp. 397-409.

[20] The exact distribution is as follows:

Number	Per cent
Six	1
Five	5
Four	11
Three	21
Two	25
One	24
None	13
Total .	100

Since the distribution of this sub-score in various population groups closely follows the distribution of the full psychological orientation score shown in Table 9-13, no further details of this sub-score will be presented.

score, the relationship is clear:[21]

	Proportion Accepting Psychiatry
Accepted underlying premises, at least in part	
Accepted almost all of the conclusions (5 or 6)	74
Accepted about half of the conclusions (3 or 4)	49
Accepted few or more of the conclusions (2 or less)	32
Did not accept underlying premises	
Accepted almost all of the conclusions (5 or 6)	39
Accepted about half of the conclusions (3 or 4)	35
Accepted few or more of the conclusions (2 or less)	24

In short, there is relatively little public acceptance of the profession of psychiatry because there is relatively little public acceptance of the ways of thinking about human behavior characteristic of psychiatry. And, so long as the general public starts from fundamental assumptions about the behavior of themselves and others quite different from the starting points of modern psychiatry, the dissemination of conclusions about the nature of mental illness derived from the latter position serves mainly to import inconsistencies into popular discussion--the kinds of anomalies, contradictions and confusions that have been evident throughout this report--without very much modifying fundamental beliefs about human behavior or basic orientations toward mental illness and psychiatry.

A More Practical Note on the Utilization of Psychiatric Services

The concentration of attention in this chapter on intellectual and emotional acceptance both of psychiatric concepts and theories and of psychiatric services is not meant to imply a correspondence between these attitudes and future utilization or non-utilization of psychiatric services.

[21] It is also clear that seeming acceptance of the general psychological approach to human behavior which does not lead on to acceptance of the related conclusions about the nature of mental illness also had no influence on attitudes toward psychiatry. In the light of the relative crudity of the index of premises, it is likely that many of the people in this group are errors of classification and did not, in fact, accept the underlying premises of psychiatry.

Many people whose attitudes and ideas about psychiatry were extremely favorable may never make use of professional services; others whose hostility and rejection of psychiatry represented the opposite pole may, nevertheless, and without prior modification of attitudes, become patients of psychiatrists. There are, quite obviously, a great many variables intervening between attitudes toward psychiatry and the decision to obtain psychiatric treatment to attenuate the connection between them.

Despite their undoubted existence, little can be said on the basis of this research about the kinds of considerations that may impel unfavorably-disposed people to obtain psychiatric treatment. A few hostile respondents did suggest that a great enough need might compel them to try even psychiatry as a last resort, while others--both hostile and favorable--sometimes noted that, if the need were severe, the decision for psychiatric treatment might not be left to the patient's choice. Aside from need and absence of choice, however, discussion was more apt to turn up deterrants--relatively objective conditions which might prevent or make more difficult the utilization of psychiatrists by even the favorably-disposed.

About a quarter of the public mentioned one or more factors, apart from absence of need or negative affect, which they regarded as likely to limit use of psychiatry. (See Table 9-14.) This relatively low reference to the more practical problems involved in seeking psychiatric treatment is in part a function of the generally low public levels of any kind of information about psychiatry already reported and in part a function of the previously discussed tendency to regard psychiatry in terms too remote to require practical considerations. Thus, with people best informed about psychiatric procedures, the percentage who spontaneously noted that there might be difficulties in the way of consulting psychiatrists rises to 43 per cent, while people who were either outspokenly hostile toward psychiatry or accepting of it were, quite apart from levels of information, a good deal more likely to comment on barriers to treatment than were those who dealt with psychiatry by the implicit rejection of polite, remote indifference--29 per cent of the hostile and 38 per cent of the accepting made such comments as over against eight per cent of the implicitly rejecting, with the differences between the hostile and the accepting being primarily a function of the lower levels of information in the hostile group, as shown below:

Knowledge of Psychiatric Procedure[22]	Proportion Commenting on Factors Believed to Deter Utilization of Psychiatry among Those: Accepting Psychiatry	Hostile to Psychiatry	Implicitly Rejecting of Psychiatry
No knowledge	22	13	2
Field of specialization exists	29	21	6
Psychiatry is name of field	27	29	6
Psychiatry is talk	35	33	11
Psychotherapy is rational	43	41	11
Psychotherapy involves emotional elements	50	55	17

[22]The category, "Psychiatry is physical therapy," is omitted because of the small number of cases.

Awareness of difficulties in the way of seeking psychiatric care was, then, not merely another way of giving indirect expression to hostility toward psychiatry and was enhanced rather than reduced by increasing general information about psychiatry. Consequently, the views of the minority who discussed impediments represent the thinking of people who were closest to psychiatry and so have greater strategic importance than their relative infrequency might otherwise suggest.

As these people saw it, the major difficulties revolved around economics, social attitudes and professional organization. Just over half the group mentioned that the costs of psychiatric treatment were more than they--or many people--could afford; a third suggested that even people who were favorably disposed toward psychiatry might be inhibited from seeking treatment through their awareness that theirs was a minority viewpoint, so that others around them would not understand or approve if they acted on it; a quarter believed that there were sufficient incompetent or disreputable psychiatrists--or pseudo-psychiatrists--practicing in a field where laymen felt unable to judge professional qualification to make people reluctant to seek treatment for fear they would fall into the hands of quacks or charlatans; a tenth suggested that there were so few psychiatrists so unevenly distributed geographically that many people interested in treatment would be unable to find a psychiatrist available.

Interestingly enough, both the more objective considerations of cost and supply and the more psychological concerns with possible social disapproval and with possible fradulent exploitation conduced to reinforce a more general tendency to assign a crucial role to the family doctor or general practitioner in any decision for or against psychiatric treatment. As contrasted with the quarter of the population who mentioned external factors which might directly influence their behavior, a third of the public volunteered the position that they would delegate the decision for or against psychiatry to a general physician--their family doctors or others. These people said one should leave it up to a doctor to decide whether a psychiatrist was needed, or they would want to ascertain first that the causes of the illness were not physical before going on to consult a psychiatrist, or they would, in any case, because of doubts and uncertainties about psychiatric standards, want their family physicians to select and make the referral to a particular psychiatrist, or, even more generally, they would do whatever their doctor recommended after consulting him about a behavioral disorder.

The third of the population who made such statements were only making explicit the prevailing assimilation of psychiatry to other medical specialties, in relation to which the general practitioner operates as a gatekeeper. As we saw earlier (see Chapter 7, pps.), the majority of the population thought they would consult a general physician in case of unusual behavior on the part of a family member, either before going on to a psychiatrist if that proved to be needed or as the only professional help they would seek on their own. Quite apart from explicit delegation of judgment about psychiatry to the general practitioner, the next effect of the sequence of steps people saw themselves as taking in dealing with emotional problems placed the general practitioner in a position to exert considerable influence for or against psychiatric treatment. If all references either (1) simply to seeing a general physician before seeing a psychiatrist, or (2) more directly to relying on the general practitioner to determine the treatment needed, including the advisability of psychiatry and, perhaps, a definite referral, or (3) even to requiring some reassurance about the competence and honesty of particular psychiatrists (since the general physician would be the most likely source to consult), then at least 66 per cent of the public appeared to accord this strategic position vis-a-vis psychiatry to the general practitioner.[23]

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[23]These projected courses of action were relatively realistic thinking as evidenced by the fact that a recent intensive study of 33 hospitalized mental patients determined that 23 of them (or 70 per cent) had been seen as patients by general physicians in the course of trying to find out what was wrong. See John A. Clausen and Marian R. Yarrow, "Paths to the Mental Hospital," Journal of Social Issues, Vol. 19, No. 4 (1955) pps. 25-32.

From previous discussion, it must be clear that most of the people who directly or obliquely established the family physician or general practitioner as the arbiter determining the utilization of psychiatric services did not think of their viewpoint as representing an external consideration deterring the use of psychiatry. On the contrary, they usually meant to describe instead a clear-cut channel facilitating the use of psychiatry and most typically spoke of seeing a psychiatrist if their doctor recommended it in order to imply an absence of reservations about consulting psychiatrists, a willingness to do so without hesitation if any need for it were authoritatively pointed out to them.

Whatever their intentions, the public's reliance in the psychiatric realm on the judgment of general practitioners could prove in practice to be a powerful deterrent to broader utilization of psychiatry. That is to say, whether the medical referral-to-psychiatry system popularly envisaged operates to facilitate or to inhibit access to psychiatry is not so much a function of whether decisions are delegated to non-psychiatric physicians as it is of the direction of the judgment exercised by them: the power to decide whether psychiatric treatment is needed is, after all, also the power to decide that it is not needed, just as the right to recommend psychiatric treatment is equally well the freedom to refrain from advising it; and, given the great popular respect for physicians and the many uncertainties and difficulties surrounding psychiatry, even the favorably-disposed could be turned away from approaching psychiatric facilities through the intervention of their doctors' negative attitudes, opposition or ridicule.

In view of the extent of medical influence, it is unfortunate, to say the least, that such evidence as exists does not support the popular assumptions that the general practitioner is well-qualified to diagnose psychiatric disorders when they present themselves or that, having done so, he will make an unbiased decision as to the necessity or desirability of their treatment by psychiatrists. Thus, in the previously-mentioned intensive study of 33 men with mental illnesses which led to hospitalization, 23 had been seen by private physicians in the course of trying to define and deal with the emerging disturbance, but only seven of the 23 seen by non-psychiatric practitioners had been referred by them to psychiatrists.

Aside from this suggestive indication of actual practice, a rather large-scale study of other doctors' attitudes toward psychiatrists and their specialty reinforces the impression of negative medical reactions to psychiatry.[24] In a sample survey of 405 non-psychiatric physicians practicing in the State of New Jersey, the 197 general practitioners among them approached psychiatry about as follows:[25]

93% felt "able to distinguish between psychoses and neuroses."

67% felt "able to treat a neurosis," even though 81 per cent did little or no "reading about psychiatry."

59% felt that less than a tenth of their patients "could benefit from the setvices of a psychiatrist," even though only 13 per cent believed that this small a percentage of their own patients "suffer from a neurosis." (Thirty-four per cent thought at least half their patients had neuroses, but only 14 per cent felt this many of their patients could benefit from psychiatry.)

54% had seen only "fair" (39%) or "poor" (15%)--rather than "good" --"results from the treatment of patients by psychiatrists for psychoses."

48% had seen only "fair" (37%) or "poor" (11%)--rather than "good"-- "results from the treatment of patients by psychiatrists for neuroses."

46% felt that "psychiatry as a medical specialty" was of "some" (42%) or "no help" (4%), but was not a "great deal of help."

11% "almost never" or "never found it useful to refer patients to a psychiatrist," as contrasted with 73 per cent who "occasionally found it useful" and 15 per cent who "often" did.

7% thought psychiatrists were not "pretty able men as compared with other specialists."

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[24]Studies of medical attitudes toward psychiatry have not been widely undertaken because the intra-professional character of the subject generally leads doctors to revert to professional correctness rather than personal frankness when talking to lay researchers. Because of this tendency the results obtained in the study about to be reported should be regarded as conservative estimates of physicians' reservations about psychiatry.

[25]I am indebted to the late Dr. Robert C. Myers, then Chief, Community Mental Health Services, Department of Institutions and Agencies of the State of New Jersey, who designed the study, and to Audience Research, Inc., who executed his design, for their kindness in giving me full access to their data and their generous permission to present my analysis and interpretation of those data here. Other reports of this study can be found in: New Jersey Department of Institutions and Agencies, New Jersey Mental Health Survey of Physicians, 1954 and Lenore Korkes, "Physicians' Attitudes toward the Mental Health Problem," Mental Hygiene, Vol. 41, No. 4. (October, 1957), pps. 467-486.

Each of the foregoing viewpoints, except the first, may be considered a kind of reservation verbalized by the doctor about either the wisdom or the necessity of referring his patients to psychiatrists--whether because the doctor felt competent to treat psychiatric disorders himself, or because he was not sanguine about therapeutic results, or because he distrusted the practitioners or the basic premises of psychiatry. In this light, at least 95 per cent of the general practitioners of New Jersey voiced some reservations about psychiatry, an attitude which was, if anything, more widespread among general practitioners than among non-psychiatric medical specialists:

Number of Verbalized Reservations about the Usefulness of Psychiatry	General Practitioners	Internists	Other Specialists
Seven	-%	2%	-%
Six	4	2	3
Five	4	7	4
Four	21	16	13
Three	33	21	25
Two	18	36	34
One	15	12	16
None	5	4	5
	100%	100%	100%
Average number of reservations			
Mean	2.8	2.7	2.5
Median	2.9	2.5	2.4

From the immediate standpoint of securing prompter and more efficient referral of petsons in need of treatment into psychiatric channels, the existence of such widespread reservations about psychiatry on the part of the medical profession is of far more practical import than any of the deterring considerations raised by informed sections of the public. There is every reason to believe that, if general practitioners were more disposed to advise psychiatric treatment, more people would seek it, irrespective of their own levels of information, attitudes or hesitancies about psychiatry. And, if the attitudes of the medical profession were more unreservedly accepting of the specialty of their psychiatric colleagues, general practitioners

might well be the most effective force for increasing lay understanding and acceptance, since doctors are the public's most highly regarded, trusted source of health information. There would still remain the problems of making psychiatric services more broadly available, both geographically and economically, but these economic and logistical problems would surely prove easier of solutions, if such wide-spread emotional barriers to psychiatry did not exist.

TABLE 4 A-1 for A-3

IMPUTED DIAGNOSTIC REFERENTS OF MENTAL ILLNESS

Imputed Diagnostic Category	Proportion Rated as Referring to Each Diagnostic Category						
		Non-Psychotic Mental Illness		"Nervous Breakdown"			
	First Impression	All Respondents	Respondents Who Believed Mental Illness Included Non-Psychotic Categories	All Respondents	Respondents Who Classified Nervous Breakdown as Mental Illness	Respondents Who Did Not Classify Nervous Breakdown as Mental Illness	Total Impression
Psychosis	34	5	6	7	11	3	38
Neurosis, emotional disorder	26	36	43	52	48	55	51
Eccentrics, psychopaths, sociopaths	3	3	3	*	*	*	5
Mental deficiency	1	1	1	-	-	-	2
Syndrome other than mental illness	1	2	2	2	1	3	3
Part of answer not classifiable above	5	2	3	1	1	1	31
Entire answer not classifiable above	39	33	40	36	41	31	25
No description	4	5	6	5	1	10	2
Total per cent	113	87[a]	104	103	103	103	157
Psychosis only	24	4	5	5	8	2	8
Psychosis and unclassified syndrome[b]	5	*	*	1	1	*	13
Psychosis and non-psychotic syndrome	5	1	1	1	2	1	17
Non-psychotic and unclassified syndrome	2	2	2	1	1	1	20
Non-psychotic syndrome only	19	33	40	50	45	53	14
Mental deficiency or non-mental illness only	1	3	3	1	1	2	*
Unclassified syndrome only	40	35	43	36	42	31	26
No description	4	5	6	5	*	10	2
Total per cent	100	83[a]	100	100	100	100	100
Number	3,531	3,531	2,914	3,531	1,682	1,849	3,531

*Less than 0.5%.

[a]Excludes 17% who did not believe mental illness included non-psychotic categories.

[b]"Unclassified syndrome" includes the category of "eccentrics, psychopaths, sociopaths."

TABLE 5A 2 for A 3-2

RELATION OF IMPUTED DIAGNOSTIC REFERENTS TO USE OF DIAGNOSTIC CATEGORIES IN FIRST IMPRESSION OF MENTAL ILLNESS

Imputed Diagnostic Category	Proportion Rated as Referring to Each Diagnostic Category			
	Respondents Who Mentioned Diagnostic Categories[a]			Respondents Who Did Not Mention Diagnostic Categories[b]
	Psychosis Only or Psychosis and Unclassified Syndrome	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome Only or Non-Psychotic and Unclassified Syndrome	
Psychosis only	83	9	7	17
Psychosis and unclassified syndrome	6	26	1	3
Psychosis and non-psychotic syndrome	4	52	2	2
Non-psychotic syndrome and unclassified syndrome	-	2	4	1
Non-psychotic syndrome only	1	*	45	17
Mental deficiency and non-mental illness only	-	-	1	*
Unclassified syndrome only	6	11	40	60
Total per cent	100	100	100	100
Number	570	243	844	1,719

*Less than 0.5%.

[a]Excludes 1% who mentioned only mental deficiency or unclassified syndromes.

[b]Excludes the 4% who could not describe mental illness.

TABLE 6 A 3 for A 3-3

RELATION OF SUMMARY CHARACTERIZATIONS TO IMPUTED DIAGNOSTIC REFERENTS IN FIRST IMPRESSION OF MENTAL ILLNESS

Summary Characterization	Proportion Mentioning Each Summary Characterization Among Those Rated As Referring to:					
	Psychosis Only	Psychosis and Unclassified Syndrome	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome and Unclassified Syndrome	Non-Psychotic Syndrome Only	Unclassified Syndrome Only
ALL RESPONDENTS						
Incompetent, lacking responsibility for actions	19	12	7	2	1	7
General deviancy only	22	22	15	25	14	31
Other mental or emotional deviancy only	22	23	22	33	19	26
No mention of summary characterization	37	43	56	40	66	36
Total per cent	100	100	100	100	100	100
Number	841	171	194	60	681	1,426
RESPONDENTS WHO MENTIONED SUMMARY CHARACTERIZATION						
Incompetent, lacking responsibility for actions	30	20	16	3	3	11
General deviancy only	35	39	34	42	40	48
Other mental or emotional deviancy only	35	41	50	55	57	41
Total per cent	100	100	100	100	100	100
Number	531	98	85	36	230	916

TABLE 7 A 4 for A Beth.

RELATION OF SUMMARY CHARACTERIZATIONS TO USE OF DIAGNOSTIC CATEGORIES IN FIRST IMPRESSION OF MENTAL ILLNESS

Summary Characterization	Proportion Mentioning Each Summary Characterization			
	Respondents Who Mentioned Diagnostic Categories[a]			Respondents Who Did Not Mention Diagnostic Categories[b]
	Psychosis Only or Psychosis and Unclassified Syndrome	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome Only or Non-Psychotic and Unclassified Syndrome	
ALL RESPONDENTS				
Incompetent, lacking responsibility for actions . .	17	11	4	8
General deviancy only	26	18	18	27
Other mental or emotional deviancy only	19	22	22	26
No mention of summary characterization	38	49	56	39
Total per cent	100	100	100	100
Number	570	243	844	1,719
RESPONDENTS WHO MENTIONED SUMMARY CHARACTERIZATION				
Incompetent, lacking responsibility for actions . .	27	21	10	14
General deviancy only	41	36	40	44
Other mental or emotional deviancy only	32	43	50	42
Total per cent	100	100	100	100
Number	351	125	377	1,041

[a] Excludes 1% who mentioned only mental deficiancy or unclassified syndromes.

[b] Excludes the 4% who could not describe mental illness.

TABLE 8 A 5th-CHAP A3

RELATION OF SPECIFIC DESCRIPTIONS TO IMPUTED DIAGNOSTIC REFERENTS OF FIRST IMPRESSION OF MENTAL ILLNESS

	Proportion Mentioning Each Specific Description Among Those Rated as Referring to:					
	Psychosis Only	Psychosis and Unclassified Syndrome	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome and Unclassified Syndrome	Non-Psychotic Syndrome Only	Unclassified Syndrome Only
ALL RESPONDENTS						
Disordered emotional tone	19	43	59	57	64	29
Intellectual impairment	39	38	34	42	27	38
Distortion of reality	27	22	44	38	31	15
Deviant external appearance	16	17	27	35	31	20
Violent acts	36	44	31	23	1	5
Violent, extreme expression	12	13	11	23	10	9
Disordered self-image, character traits	2	3	22	32	26	5
Health impairment	3	7	17	12	23	5
Speech mannerisms, disorders	9	8	7	8	5	9
Exceptional, unusual behavior	13	14	5	5	1	5
Anti-social habits	2	13	11	25	2	4
No specific description	15	12	9	-	2	24
Total per cent[a]	193	234	277	300	223	168
Number	841	171	194	60	681	1,426
RESPONDENTS WHO MENTIONED SPECIFIC DESCRIPTION						
Disordered emotional tone	22	49	64	57	65	38
Intellectual impairment	46	43	37	42	27	49
Distortion of reality	32	25	48	38	31	20
Deviant external appearance	18	19	30	35	32	25
Violent acts	42	51	34	23	1	6
Violent, extreme expression	14	15	12	23	10	12
Disordered self-image, character traits	2	3	24	32	27	7
Health impairment	4	8	19	12	23	7
Speech mannerisms, disorders	11	9	8	8	5	12
Exceptional, unusual behavior	15	16	6	5	1	7
Anti-social habits	2	14	12	25	2	5
Total per cent[a]	208	252	294	300	224	188
Number	713	150	177	60	670	1,090

[a]Totals exceed 100% because most respondents mentioned more than one type of specific description.

TABLE 9 Also appA 3

RELATION OF SPECIFIC DESCRIPTIONS TO DIAGNOSTIC CATEGORIES USED IN FIRST IMPRESSION OF MENTAL ILLNESS

Specific Description	Proportion Mentioning Each Specific Description			
	Respondents Who Referred to Diagnostic Categories[a]			Respondents Who Did Not Refer to Diagnostic Categories[b]
	Psychoses Only or Psychosis and Unclassified Syndrome	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome Only or Non-Psychotic and Unclassified Syndrome	
ALL RESPONDENTS				
Distorted emotional tone	21	43	47	36
Intellectual impairment	34	30	34	38
Distortion of reality	21	29	19	26
Deviant external appearance	16	19	35	17
Violent acts	29	21	7	14
Violent, extreme expression	11	11	10	10
Disordered self-image, character traits	4	11	11	11
Health impairment	3	12	15	8
Speech mannerisms, disorders	9	8	7	8
Exceptional, unusual behavior	12	7	3	7
Anti-social habits	3	7	4	5
No specific description	22	17	13	14
Total per cent[c]	185	215	205	194
Number	570	243	844	1,719
RESPONDENTS WHO MENTIONED SPECIFIC DESCRIPTION				
Distorted emotional tone	26	52	54	42
Intellectual impairment	44	36	38	44
Distortion of reality	27	35	22	30
Deviant external appearance	20	23	40	20
Violent acts	37	25	8	17
Violent, extreme expression	14	13	12	12
Disordered self-image, character traits	5	13	13	13
Health impairment	4	15	17	9
Speech mannerisms, disorders	11	10	8	10
Exceptional, unusual behavior	16	8	3	8
Anti-social habits	4	8	4	5
Total per cent[c]	208	238	219	210
Number	444	201	738	1,467

[a]Excludes 1% who mentioned only mental deficiency or unclassified syndromes.

[b]Excludes the 4% who could not describe mental illness.

[c]Totals exceed 100% because most respondents mentioned more than one type of specific description.

TABLE 10 A7 from App A3

RELATIVE FREQUENCY OF REFERENCE TO PSYCHOSIS AND NON-PSYCHOTIC SYNDROMES FOR GROUPS USING DIFFERENT MODES OF DESCRIPTION IN FIRST IMPRESSION OF MENTAL ILLNESS

Descriptive Group	Ratio of Reference to Psychosis to Reference to Non-Psychotic Syndrome in Indicated Descriptive Group	
	Respondent Mentions	Rater Imputations
Specific description and		
No summary characterization	0.5	0.8
Summary characterization	0.8	1.8
No specific description and		
No summary characterization	0.8	4.6
Summary characterization	1.5	6.9
Type of summary characterization:		
Incompetency	1.9	9.2
General deviancy only	1.0	1.9
Other mental or emotional deviancy only	0.7	1.4
None	0.6	0.8
Type of specific description:		
Exceptional, unusual behavior	2.1	8.5
Violent acts	2.0	5.4
Speech mannerisms, disorders	0.9	2.1
Intellectual impairment	0.8	1.7
Violent, extreme expression	0.8	1.4
Anti-social habits	0.8	1.2
Distortion of reality	0.8	1.1
Deviant external appearance	0.4	0.7
Disordered emotional tone	0.4	0.6
Health impairment	0.3	0.4
Disordered self-image, character traits	0.4	0.3

TABLE 11 A8-footnote A3

SEVERITY OF SPECIFIC DESCRIPTIONS OF MENTAL ILLNESS

Severity of Specific Description	Proportion Mentioning Specific Description of Each Severity													
	First Impression		Non-Psychotic Mental Illness			"Nervous Breakdown"						Total Impression	
	All Respondents	Respondents Mentioning Any Specific Description	All Respondents	Respondents Who Believed Mental Illness Included Non-Psychotic Categories		All Respondents		Respondents Who Classified Nervous Breakdown as Mental Illness		Respondents Who Did Not Classify Nervous Breakdown as Mental Illness		All Respondents	Respondents Mentioning Any Specific Description
				Total	Those Mentioning Any Specific Description	Total	Those Mentioning Any Specific Description	Total	Those Mentioning Any Specific Description	Total	Those Mentioning Any Specific Description		
DISORDERED EMOTIONAL TONE													
Psychotic	-	-	-	-	-	-	-	-	-	-	-	-	-
Indeterminate	5	6	4	5	6	7	8	7	8	7	8	9	10
Non-psychotic	33	41	31	38	51	37	46	39	47	35	45	53	59
INTELLECTUAL IMPAIRMENT													
Psychotic	19	24	6	8	10	5	6	7	8	4	5	24	27
Indeterminate	7	8	5	6	8	9	11	9	11	8	11	13	14
Non-psychotic	14	17	11	13	18	10	13	13	15	8	10	24	27
DISTORTION OF REALITY													
Psychotic	6	7	1	1	2	1	1	2	2	*	*	7	8
Indeterminate	15	18	11	13	17	7	9	10	12	5	6	23	25
Non-psychotic	5	6	4	5	7	2	3	3	4	2	2	8	9
DEVIANT EXTERNAL APPEARANCE													
Psychotic	7	8	3	3	4	2	3	2	3	2	2	9	10
Indeterminate	3	4	1	2	2	2	2	2	2	2	2	5	5
Non-psychotic	13	16	13	16	21	27	34	26	31	28	36	29	32
VIOLENT ACTS													
Psychotic	12	15	2	2	3	2	3	4	5	1	2	15	16
Indeterminate	5	6	1	1	2	2	3	3	4	1	2	7	7
Non-psychotic	-	-	-	-	-	-	-	-	-	-	-	-	-

*Less than 0.5%.

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TABLE 11--Continued

Severity of Specific Description	Proportion Mentioning Specific Description of Each Severity												
	First Impression		Non-Psychotic Mental Illness			"Nervous Breakdown"						Total Impression	
	All Respondents	Respondents Mentioning Any Specific Description	All Respondents	Respondents Who Believed Mental Illness Included Non-Psychotic Categories		All Respondents		Respondents Who Classified Nervous Breakdown as Mental Illness		Respondents Who Did Not Classify Nervous Breakdown as Mental Illness		All Respondents	Respondents Mentioning Any Specific Description
				Total	Those Mentioning Any Specific Description	Total	Those Mentioning Any Specific Description	Total	Those Mentioning Any Specific Description	Total	Those Mentioning Any Specific Description		
VIOLENT, EXTREME EXPRESSION													
Psychotic	2	3	1	1	1	1	2	2	2	1	2	3	4
Indeterminate	9	11	6	8	10	18	23	20	24	17	21	29	22
Non-psychotic	-	-	-	-	-	-	-	-	-	-	-	-	-
DISORDERED SELF-IMAGE													
Psychotic	-	-	-	-	-	-	-	-	-	-	-	-	-
Indeterminate	-	-	-	-	-	-	-	-	-	-	-	-	-
Non-psychotic	9	12	10	12	16	7	8	9	10	5	6	17	19
HEALTH IMPAIRMENT													
Psychotic	-	-	-	-	-	-	-	-	-	-	-	-	-
Indeterminate	-	-	-	-	-	-	-	-	-	-	-	-	-
Non-psychotic	9	11	9	11	14	39	48	36	43	41	52	28	31
SPEECH MANNERISMS, DISORDERS													
Psychotic	4	5	1	1	2	1	1	1	1	1	1	5	6
Indeterminate	4	5	2	3	4	2	2	2	3	1	2	6	7
Non-psychotic	-	-	-	-	-	-	-	-	-	-	-	-	-
EXCEPTIONAL, UNUSUAL BEHAVIOR													
Psychotic	3	4	1	1	1	1	1	1	1	*	*	4	5
Indeterminate	3	4	1	1	2	*	*	1	1	*	*	5	5
Non-psychotic	-	-	-	-	-	-	-	-	-	-	-	-	-

TABLE 11--Continued

Severity of Specific Description	Proportion Mentioning Specific Description of Each Severity											
	First Impression		Non-Psychotic Mental Illness			"Nervous Breakdown"						Total Impression	
	All Respondents	Respondents Mentioning Any Specific Description	All Respondents	Respondents Who Believed Mental Illness Included Non-Psychotic Categories		All Respondents		Respondents Who Classified Nervous Breakdown as Mental Illness		Respondents Who Did Not Classify Nervous Breakdown as Mental Illness		All Respondents	Respondents Mentioning Any Specific Description
				Total	Those Mentioning Any Specific Description	Total	Those Mentioning Any Specific Description	Total	Those Mentioning Any Specific Description	Total	Those Mentioning Any Specific Description		
ANTI-SOCIAL BEHAVIOR													
Psychotic	-	-	-	-	-	-	-	-	-	-	-	-	-
Indeterminate	4	5	3	4	5	1	2	2	2	1	1	7	8
Non-psychotic	-	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL													
Psychotic	40	49	13	16	21	12	14	15	19	8	10	48	53
Indeterminate	41	50	29	34	46	39	48	44	52	34	43	58	64
Non-psychotic	54	67	48	59	79	72	89	72	87	72	91	76	83
No specific description	19	-	39	26	-	19	-	17	-	21	-	10	-
Total per cent[a]	154	166	129	135	146	142	151	148	158	135	144	192	200
Psychotic only	12	15	4	5	7	2	2	2	3	1	1	6	7
Psychotic and indeterminate	9	10	2	2	3	2	2	3	3	1	2	5	6
Psychotic, non-psychotic and indeterminate	10	13	3	4	5	5	6	6	8	3	4	26	28
Psychotic and non-psychotic	9	11	4	5	6	3	4	4	5	3	3	11	12
Non-psychotic and indeterminate	16	19	17	20	27	27	33	29	34	25	31	24	26
Non-psychotic only	19	24	24	30	41	37	46	33	40	41	53	15	17
Indeterminate only	6	8	7	8	11	5	7	6	7	5	6	3	4
No specific description	19	-	39	26	-	19	-	17	-	21	-	10	-
Total per cent	100	100	100	100	100	100	100	100	100	100	100	100	100
Number	3,531	2,860	3,531	2,914	2,166	3,531	2,862	1,682	1,401	1,849	1,461	3,531	3,184

[a]Totals exceed 100% because many respondents mentioned symptoms of different degrees of severity.

TABLE 12 Aptatt 13

RELATION OF SEVERITY OF SPECIFIC DESCRIPTION TO IMPUTED DIAGNOSTIC REFERENT OF FIRST IMPRESSION OF MENTAL ILLNESS

	Proportion Mentioning Specific Description of Each Severity Among Those Rated as Referring to:					
	Psychosis Only	Psychosis and Unclassified Syndrome	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome and Unclassified Syndrome	Non-Psychotic Syndrome Only	Unclassified Syndrome Only
ALL RESPONDENTS						
Psychotic	73	64	42	40	7	37
Indeterminate	42	53	61	81	40	38
Non-psychotic	29	53	82	92	95	49
No specific description	15	12	9	-	2	24
Total per cent	159	182	194	213	144	148
Psychotic only	31	11	*	-	*	11
Psychotic and indeterminate	20	15	5	5	*	7
Psychotic, indeterminate, non-psychotic	12	21	26	23	3	9
Psychotic and non-psychotic	10	17	11	12	4	10
Non-psychotic and indeterminate	5	8	26	50	34	13
Non-psychotic only	2	7	19	7	54	17
Indeterminate only	5	9	4	3	3	9
No specific description	15	12	9	-	2	24
Total per cent	100	100	100	100	100	100
Number	841	171	194	60	681	1,426

*Less than 0.5%.

Appendix A 43

TABLE ~~12~~--Continued

Severity of Specific Description	Proportion Mentioning Specific Description of Each Severity Among Those Rated as Referring to:					
	Psychosis Only	Psychosis and Unclassified Syndrome	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome and Unclassified Syndrome	Non-Psychotic Syndrome Only	Unclassified Syndrome Only
RESPONDENTS MENTIONING SPECIFIC DESCRIPTION						
Psychotic	87	73	46	40	7	49
Indeterminate	50	61	67	81	41	50
Non-psychotic	34	62	90	92	97	64
Total per cent	171	196	203	213	145	163
Psychotic only	36	11	1	-	*	15
Psychotic and indeterminate . . .	24	17	5	5	*	9
Psychotic, indeterminate, non-psychotic	15	25	29	23	3	12
Psychotic and non-psychotic . . .	12	20	11	12	4	13
Non-psychotic and indeterminate .	5	9	29	50	35	17
Non-psychotic only	2	8	21	7	55	22
Indeterminate only	6	10	4	3	3	12
Total per cent	100	100	100	100	100	100
Number	713	150	177	60	670	1,090

TABLE ~~13~~ A 10 of all 13

RELATION OF SEVERITY OF SPECIFIC DESCRIPTION TO DIAGNOSTIC CATEGORIES USED IN FIRST IMPRESSION OF MENTAL ILLNESS

Severity of Specific Description	Proportion Mentioning Specific Description of Each Severity			
	Respondents Who Referred to Diagnostic Categories[a]			Respondents Who Did Not Refer to Diagnostic Categories[b]
	Psychoses Only or Psychosis and Unclassified Syndrome	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome Only or Non-Psychotic and Unclassified Syndrome	
ALL RESPONDENTS				
Psychotic	58	38	26	44
Indeterminate	39	46	38	45
Non-psychotic	29	62	74	56
No specific description	22	17	13	14
Total per cent	148	163	151	159
Psychotic only	25	9	6	13
Psychotic and indeterminate	17	5	3	10
Psychotic, indeterminate, non-psychotic	8	15	9	11
Psychotic and non-psychotic	8	9	8	10
Non-psychotic and indeterminate	7	19	22	17
Non-psychotic only	6	19	35	18
Indeterminate only	7	7	4	7
No specific description	22	17	13	14
Total per cent	100	100	100	100
Number	570	243	844	1,719

[a]Excludes 1% who mentioned only mental deficiency or unclassified syndromes.

[b]Excludes the 4% who could not describe mental illness.

TABLE 13--Continued

Severity of Specific Description	Proportion Mentioning Specific Description of Each Severity			
	Respondents Who Referred to Diagnostic Categories[a]			Respondents Who Did Not Refer to Diagnostic Categories[b]
	Psychoses Only or Psychosis and Unclassified Syndrome	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome Only or Non-Psychotic and Unclassified Syndrome	
RESPONDENTS MENTIONING SPECIFIC DESCRIPTION				
Psychotic	75	46	29	51
Indeterminate	51	56	44	52
Non-psychotic	38	76	85	65
Total per cent	164	178	158	168
Psychotic only	31	10	7	15
Psychotic and indeterminate	22	6	3	11
Psychotic, indeterminate, non-psychotic	11	18	10	13
Psychotic and non-psychotic	11	12	9	12
Non-psychotic and indeterminate	9	24	26	19
Non-psychotic only	7	22	40	21
Indeterminate only	9	8	5	9
Total per cent	100	100	100	100
Number	444	201	738	1,467

TABLE 4A (Ch 13)

RELATION OF IMPUTED DIAGNOSTIC REFERENT TO SEVERITY OF SPECIFIC DESCRIPTION OF FIRST IMPRESSION OF MENTAL ILLNESS

Imputed Diagnostic Category	Proportion Rated as Referring to Each Diagnostic Category								
	Respondents Who Mentioned Specific Description							Respondents Who Did Not Mention Specific Description	
	Psychotic Only	Psychotic and Indeterminate	Psychotic, Indeterminate and Non-psychotic	Psychotic and Non-Psychotic	Non-Psychotic and Indeterminate	Non-Psychotic Only	Indeterminate Only	Mentioned Summary Characterization	Did Not Mention Summary Characterization[a]
ALL RESPONDENTS									
Psychosis only	59	56	29	28	7	2	20	25	24
Psychosis and unclassified syndrome	4	8	11	9	3	2	7	2	10
Psychosis and non-psychotic syndrome	*	3	14	7	9	5	3	3	5
Non-psychotic syndrome and unclassified syndrome	-	1	4	2	5	1	1	-	-
Non-psychotic syndrome only	*	1	6	8	42	55	8	2	3
Unclassified syndrome only	37	31	36	46	34	35	61	68	58
Total per cent	100	100	100	100	100	100	100	100	100
Number	440	302	356	310	555	674	223	371	142
RESPONDENTS FOR WHOM SOME IMPUTATION WAS MADE									
Psychosis only	93	81	45	51	10	3	52	80	57
Psychosis and unclassified syndrome	7	12	16	18	4	3	18	6	23
Psychosis and non-psychotic syndrome	*	4	23	13	14	8	8	9	12
Non-psychotic syndrome and unclassified syndrome	-	2	6	4	8	1	2	-	-
Non-psychotic syndrome only	*	1	10	14	64	85	20	5	8
Total per cent	100	100	100	100	100	100	100	100	100
Number	278	208	228	168	366	436	86	117	60

*Less than 0.5%.

[a]Excludes the 4% who could not describe mental illness and 1% for whom no description was coded because they were judged to be describing mental deficiency or syndromes other than mental illness.

Chapter 3 Tables: revised

TABLE 1

FINAL RATING OF DIAGNOSTIC REFERENTS OF MENTAL ILLNESS

Imputed Diagnostic Category	Proportion Rated as Referring to Each Diagnostic Category						
		Non-Psychotic Mental Illness		"Nervous Breakdown"			
	First Impression	All Respondents	Respondents Who Believed Mental Illness Included Non-Psychotic Categories	All Respondents	Respondents Who Classified Nervous Breakdown as Mental Illness	Respondents Who Did Not Classify Nervous Breakdown as Mental Illness	"Total" Impression
Psychosis only	50	13	16	18	25	12	22
Psychosis and non-psychotic syndrome	12	2	2	2	3	1	45
Non-psychotic syndrome only	33	58	70	72	70	73	30
Mental deficiency or non-mental illness only	1	5	6	3	2	5	1
No description	4	5	6	5	*	9	2
Total per cent	100	83[a]	100	100	100	100	100
Number	3,531	3,531	2,914	3,531	1,682	1,849	3,531

*Less than 0.5%.

[a]Excludes 17% who did not believe mental illness included non-psychotic categories.

TABLE 2

SPONTANEOUS REFERENCES TO DIAGNOSTIC CATEGORIES IN DESCRIPTION OF MENTAL ILLNESS

Diagnostic Category Spontaneously Referred to	Proportion Mentioning Each Diagnostic Category									
	First Impression		Non-Psychotic Mental Illness			"Nervous Breakdown"			"Total" Impression	
	All Respondents	Respondents Mentioning Any Category	All Respondents	Respondents Who Believed Mental Illness Included Non-Psychotic Categories: Total	Respondents Who Believed Mental Illness Included Non-Psychotic Categories: Those Mentioning Any Category	All Respondents	Respondents Who Classified Nervous Breakdown as Mental Illness: Total	Respondents Who Classified Nervous Breakdown as Mental Illness: Those Mentioning Any Category	All Respondents	Respondents Mentioning Any Category
Psychosis (popular equivalent)	23	49	1	1	3	4	9	68	26	42
Nerves, nervousness, nervous disorder	21	43	21	25	73	a	a	a	32	52
Non-psychotic mental illness	4	9	a	a	a	2	4	29	6	9
Nervous breakdown	3	7	3	4	10	a	a	a	6	9
Neurosis, emotional disorder	3	7	4	5	14	1	1	10	5	8
Eccentrics, psychopaths, sociopaths	1	1	1	1	2	-	-	-	1	2
Mental deficiency	1	1	1	1	2	-	-	-	1	2
Part of answer referred to undesignated syndromes	4	8	1	1	3	-	-	-	5	8
No reference to diagnostic categories	49	-	50	60	-	37	86	-	37	-
Couldn't describe	4	-	5	6	-	5	1	-	2	-
Not accepted as mental illness	-	-	17	-	-	52	-	-	-	-
Total per cent[b]	113	125	104	104	107	101	101	107	121	132

[a]Spontaneous reference to this category was not possible.

[b]Totals exceed 100% because some respondents mentioned more than one diagnostic category.

TABLE 2--Continued

Diagnostic Category Spontaneously Referred to	Proportion Mentioning Each Diagnostic Category									
	First Impression		Non-Psychotic Mental Illness			"Nervous Breakdown"			"Total" Impression	
	All Respondents	Respondents Mentioning Any Category	All Respondents	Respondents Who Believed Mental Illness Included Non-Psychotic Categories		All Respondents	Respondents Who Classified Nervous Breakdown as Mental Illness		All Respondents	Respondents Mentioning Any Category
				Total	Those Mentioning Any Category		Total	Those Mentioning Any Category		
Psychosis only	14	30	1	1	2	4	8	61	12	19
Psychosis and unclassified syndrome[c]	2	4	*	*	*	-	-	-	2	3
Psychosis and non-psychotic syndrome[d]	7	15	*	*	1	*	1	7	12	20
Non-psychotic syndrome and unclassified syndrome	2	3	1	1	4	-	-	-	3	5
Non-psychotic syndrome only	22	47	25	31	90	2	4	32	31	51
Unclassified syndrome only	49	1	51	61	3	37	86	-	38	2
Couldn't describe	4	-	5	6	-	5	1	-	2	-
Not accepted as mental illness	-	-	17	-	-	52	-	-	-	-
Total per cent	100	100	100	100	100	100	100	100	100	100
Number	3,531	1,678	3,531	2,914	1,001	3,531	1,682	216	3,531	2,157

*Less than 0.5%.

[c]The category of "unclassified syndrome" includes "eccentrics, psychopaths, sociopaths" and undesignated syndromes.

[d]The category of "non-psychotic syndrome" includes the categories, "nerves, nervousness, nervous disorders," "non-psychotic mental illness," "nervous breakdown" and "neurosis, emotional disorder."

TABLE 3

SPONTANEOUS REFERENCES TO DIAGNOSTIC CATEGORIES USED IN DESCRIBING DIFFERENT MENTAL ILLNESS SYNDROMES

Diagnostic Category Spontaneously Referred to	Proportion Making Each Spontaneous Reference Among Those Rated as Describing Given Syndrome											
	First Impression			Non-Psychotic Mental Illness			"Nervous Breakdown"			"Total" Impression		
	Psychosis Only	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome Only	Psychosis Only	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome Only	Psychosis Only	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome Only	Psychosis Only	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome Only
Psychosis (popular equivalent)	30	69	3	6	12	*	15	23	2	41	35	5
Nerves, nervousness, nervous disorder	13	35	33	15	24	30	a	a	a	16	35	41
Non-psychotic mental illness	4	11	4	a	a	a	1	17	2	5	8	7
Nervous breakdown	3	5	5	4	5	4	a	a	a	4	7	5
Neurosis, emotional disorder	*	20	4	1	20	5	-	9	*	1	6	7
Eccentrics, psychopaths, sociopaths	1	3	*	1	5	1	-	-	-	*	2	1
Mental deficiency	1	1	*	1	*	1	-	-	-	1	2	*
Part of answer referred to undesignated syndromes	2	16	2	2	16	1	-	-	-	3	6	5
No reference to diagnostic categories	53	17	52	74	52	60	49	54	44	41	34	43
Not accepted as mental illness	-	-	-	-	-	-	35	20	52	-	-	-
Total per cent[b]	107	177	103	104	134	102	100	123	100	112	135	114

*Less than 0.5%.

[a]Spontaneous reference to this category was not possible.

[b]Totals exceed 100% because some respondents mentioned more than one diagnostic category.

TABLE 3--Continued

Diagnostic Category Spontaneously Referred to	Proportion Making Each Spontaneous Reference Among Those Rated as Describing Given Syndrome											
	First Impression			Non-Psychotic Mental Illness			"Nervous Breakdown"			"Total" Impression		
	Psychosis Only	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome Only	Psychosis Only	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome Only	Psychosis Only	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome Only	Psychosis Only	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome Only
Psychosis only.	26	3	2	5	-	*	15	-	2	32	11	1
Psychosis and unclassified syndrome[c]	2	12	*	1	-	-	-	-	-	2	9	1
Psychosis and non-psychotic syndrome[d]	2	54	1	*	12	*	*	23	*	7	21	3
Non-psychotic syndrome and unclassified syndrome.	1	5	2	1	20	1	-	-	-	1	3	4
Non-psychotic syndrome only	15	9	43	18	16	38	1	3	2	17	27	48
Unclassified syndrome only.	54	17	52	75	52	61	49	54	44	41	35	43
Not accepted as mental illness. . .	-	-	-	-	-	-	35	20	52	-	-	-
Total per cent	100	100	100	100	100	100	100	100	100	100	100	100
Number	1,758	424	1,158	459	64	2,012	652	66	2,517	787	1,582	1,060

*Less than 0.5%.

[c]The category of "unclassified syndrome" includes "eccentrics, psychopaths, sociopaths" and undesignated syndromes.

[d]The category of "non-psychotic syndrome" includes the categories, "nerves, nervousness, nervous disorders," "non-psychotic mental illness," "nervous breakdown" and "neurosis, emotional disorder."

TABLE 4

SUMMARY CHARACTERIZATIONS OF MENTAL ILLNESS

Summary Characterization	Proportion Mentioning Each Characterization											
	First Impression		Non-Psychotic Mental Illness			"Nervous Breakdown"					"Total" Impression	
	All Respondents	Respondents Who Used Summary Characterizations	All Respondents	Respondents Who Believed Mental Illness Included Non-Psychotic Categories		All Respondents		Respondents Who Classified Nervous Breakdown as Mental Illness		Respondents Who Did Not Classify Nervous Breakdown as Mental Illness		All Respondents	Respondents Who Used Summary Characterizations
				Total	Those Who Used Summary Characterizations	Total	Those Who Used Summary Characterizations	Total	Those Who Used Summary Characterizations	Total	Those Who Used Summary Characterizations		
Incompetent, lacking responsibility for actions	8	16	1	2	5	3	8	5	11	1	4	11	17
Other mental or emotional deviancy[a]	25	46	14	17	52	30	83	35	81	25	86	41	61
Irrational, inexplicable, illogical, unreasonable	9	16	4	5	15	5	14	7	16	3	11	13	20
Uncontrolled, lacking self-control	7	13	5	6	19	24	68	27	63	22	74	22	32
Immature, childish	4	7	2	2	7	*	1	1	2	*	1	5	8
Unstable, changeable, capricious	3	6	2	3	9	1	2	1	2	1	2	5	7
Unpredictable, impulsive, erratic	2	4	1	1	3	*	1	1	1	*	1	3	4
Unreliable, undependable	2	3	1	1	3	1	2	1	3	*	1	3	4
Extreme, excessive	1	2	1	1	4	1	2	1	2	*	1	2	3

*Less than 0.5%.

[a]Totals for this category are less than the sum of sub-categories because an individual may be classified in more than one sub-category.

TABLE 4--Continued

Summary Characterizations	Proportion Mentioning Each Characterization											
	First Impression		Non-Psychotic Mental Illness			"Nervous Breakdown"						"Total" Impression	
	All Respondents	Respondents Who Used Summary Characterizations	All Respondents	Respondents Who Believed Mental Illness Included Non-Psychotic Categories: Total	Respondents Who Believed Mental Illness Included Non-Psychotic Categories: Those Who Used Summary Characterizations	All Respondents: Total	All Respondents: Those Who Used Summary Characterizations	Respondents Who Classified Nervous Breakdown as Mental Illness: Total	Respondents Who Classified Nervous Breakdown as Mental Illness: Those Who Used Summary Characterizations	Respondents Who Did Not Classify Nervous Breakdown as Mental Illness: Total	Respondents Who Did Not Classify Nervous Breakdown as Mental Illness: Those Who Used Summary Characterizations	All Respondents	Respondents Who Used Summary Characterizations
General deviancy	23	42	12	14	44	4	11	5	12	3	11	21	30
Socially deviant ("not like other people")	7	12	3	4	12	1	2	1	3	*	2	6	9
Personally deviant ("not like himself")	2	4	1	1	4	1	4	2	5	1	3	2	3
Disordered, abnormal, not further specified ("queer," "peculiar," etc.).	14	26	8	9	28	2	5	2	4	2	6	13	18
No mention of summary characterization.	46	--	73	67	--	64	--	57	--	71	--	32	--
Total per cent[b] . . .	102	104	100	100	101	101	102	102	104	100	101	105	108
Number	3,531	1,896	3,531	2,914	962	3,531	1,269	1,682	724	1,849	545	3,531	2,390

[b]Totals exceed 100% because persons who used both formulations classifiable as "Incompetent" and those representative of "Other mental or emotional deviancy" are counted in both categories.

TABLE 5

SUMMARY CHARACTERIZATIONS USED IN DESCRIBING DIFFERENT MENTAL ILLNESS SYNDROMES

Summary Characterization	Proportion Using Each Summary Characterization Among Those Rated as Describing Given Syndrome											
	First Impression			Non-Psychotic Mental Illness			"Nervous Breakdown"			"Total" Impression		
	Psychosis Only	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome Only	Psychosis Only	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome Only	Psychosis Only	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome Only	Psychosis Only	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome Only
ALL RESPONDENTS												
Incompetent, lacking responsibility for actions.	12	7	4	7	-	1	9	9	2	17	13	6
Other mental or emotional deviancy[a]	27	25	24	25	16	18	36	40	31	33	46	44
Irrational, inexplicable, illogical, unreasonable.	10	12	7	9	-	5	7	11	5	11	16	13
Uncontrolled, lacking self-control	7	8	8	5	12	7	28	29	25	11	25	25
Immature, childish.	5	3	2	8	5	2	1	3	*	8	6	4
Unstable, changeable, capricious.	2	5	4	2	3	3	1	9	1	3	6	6
Unpredictable, impulsive, erratic	3	*	2	2	-	1	1	-	*	4	3	3
Unreliable, undependable.	2	*	2	1	-	1	1	3	1	2	3	3
Extreme, excessive.	1	*	2	1	2	1	*	3	1	1	2	3

*Less than 0.5%.

[a]Totals for this category are less than the sum of sub-categories because an individual may be classified in more than one sub-category.

TABLE 5--Continued

Summary Characterization	Proportion Using Each Summary Characterization Among Those Rated as Describing Given Syndrome											
	First Impression			Non-Psychotic Mental Illness			"Nervous Breakdown"			"Total" Impression		
	Psychosis Only	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome Only	Psychosis Only	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome Only	Psychosis Only	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome Only	Psychosis Only	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome Only
ALL RESPONDENTS												
General deviancy	28	18	21	20	19	17	7	6	4	24	23	18
Socially deviant ("not like other people").	7	8	7	6	5	5	1	-	1	5	7	5
Personally deviant ("not like himself").	3	2	4	2	2	2	3	3	1	2	3	2
Disordered, abnormal, not further specified ("queer," "peculiar," etc.	18	8	10	12	12	10	3	3	2	17	13	11
No mention of summary characterization	35	53	53	52	74	64	53	51	63	29	28	35
Total per cent[b]	102	103	102	104	109	100	105	106	100	103	110	103
Number	1,758	424	1,158	459	64	2,012	652	66	2,517	787	1,582	1,060

[b]Totals exceed 100% because persons who used both formulations classifiable as "Incompetent" and those representative of "Other mental or emotional deviancy" are counted in both categories.

TABLE 5--Continued

Summary Characterization	Proportion Using Each Summary Characterization Among Those Rated as Describing Given Syndrome											
	First Impression			Non-Psychotic Mental Illness			"Nervous Breakdown"			"Total" Impression		
	Psychosis Only	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome Only	Psychosis Only	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome Only	Psychosis Only	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome Only	Psychosis Only	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome Only
RESPONDENTS WHO USED SUMMARY CHARACTERIZATIONS												
Incompetent, lacking responsibility for action.	19	15	8	14	c	4	19	19	5	23	18	9
Other mental or emotional deviancy[a]	41	53	51	52		51	77	81	84	46	63	68
Irrational, inexplicable, illogical, unreasonable	16	26	15	18		15	15	22	13	16	22	20
Uncontrolled, lacking self-control	11	17	18	12		20	61	59	70	16	34	39
Immature, childish	8	7	5	16		6	2	6	1	11	8	6
Unstable, changeable, capricious .	4	11	10	5		10	1	19	2	4	8	9
Unpredictable, impulsive, erratic.	4	1	4	4		2	2	-	1	5	4	4
Unreliable, undependable	3	1	5	2		3	2	6	2	3	4	5
Extreme, excessive	1	1	5	3		4	1	6	2	1	3	5

[a]Totals for this category are less than the sum of sub-categories because an individual may be classified in more than one sub-category.

TABLE 5--Continued

Summary Characterization	Proportion Using Each Summary Characterization Among Those Rated as Describing Given Syndrome											
	First Impression			Non-Psychotic Mental Illness			"Nervous Breakdown"			"Total" Impression		
	Psychosis Only	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome Only	Psychosis Only	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome Only	Psychosis Only	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome Only	Psychosis Only	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome Only
RESPONDENTS WHO USED SUMMARY CHARACTERIZATIONS												
General deviancy	44	38	45	42	c	46	14	12	11	34	32	28
Socially deviant ("not like other people")	11	17	15	12		12	2	-	3	7	10	8
Personally deviant ("not like himself")	5	4	9	5		6	6	6	3	3	4	4
Disordered, abnormal, not further specified ("queer," "peculiar," etc.)	28	17	21	25		28	6	6	5	24	18	16
Total per cent[b]	104	106	104	108		101	110	112	100	103	113	105
Number	1,149	199	548	221	17	724	308	32	929	559	1,145	686

[b]Totals exceed 100% because persons who used both formulations classifiable as "Incompetent" and those representative of "Other mental or emotional deviancy" are counted in both categories.

[c]Too few cases to report percentages.

TABLE 6

SPECIFIC DESCRIPTIONS OF MENTAL ILLNESS

Specific Description	Proportion Mentioning Each Specific Description												
	First Impression		Non-Psychotic Mental Illness			"Nervous Breakdown"						'Total' Impression	
	All Respondents	Respondents Mentioning Any Specific Description	All Respondents	Respondents Who Believed Mental Illness Included Non-Psychotic Categories: Total	Respondents Who Believed Mental Illness Included Non-Psychotic Categories: Those Mentioning Any Specific Description	All Respondents: Total	All Respondents: Those Mentioning Any Specific Description	Respondents Who Classified Nervous Breakdown as Mental Illness: Total	Respondents Who Classified Nervous Breakdown as Mental Illness: Those Mentioning Any Specific Description	Respondents Who Did Not Classify Nervous Breakdown as Mental Illness: Total	Respondents Who Did Not Classify Nervous Breakdown as Mental Illness: Those Mentioning Any Specific Description	All Respondents	Respondents Mentioning Any Specific Description
SUMMARY:													
DISORDERED EMOTIONAL TONE . .	35	43	33	40	53	40	49	42	50	39	49	55	61
INTELLECTUAL IMPAIRMENT . . .	34	42	21	25	34	21	26	25	30	18	23	47	52
DISTORTION OF REALITY	23	28	15	18	25	10	12	14	17	7	8	32	35
DEVIANT EXTERNAL APPEARANCE .	21	25	16	19	26	30	37	29	35	31	39	37	41
VIOLENT ACTS	15	18	3	3	4	4	5	6	7	2	3	19	21
VIOLENT, EXTREME EXPRESSION .	10	12	7	8	11	19	23	20	24	17	21	21	23
DISORDERED SELF-IMAGE, CHARACTER TRAITS	9	12	10	12	16	7	8	9	10	5	6	17	19
HEALTH IMPAIRMENT	9	11	9	11	14	39	48	36	43	41	52	28	31
SPEECH, MANNERISMS, DISORDERS	8	9	3	4	5	3	3	3	4	2	3	11	12
EXCEPTIONAL, UNUSUAL BEHAVIOR	6	8	2	2	3	1	1	2	2	*	1	8	9
ANTI-SOCIAL HABITS	4	5	3	4	5	1	2	2	2	1	1	7	8
NO SPECIFIC DESCRIPTION . . .	19	-	39	26	-	19	-	17	-	21	-	10	-
Total per cent[a]	193	213	161	172	196	194	214	205	224	184	206	292	312
Number	3,531	2,860	3,531	2,914	2,166	3,531	2,862	1,682	1,401	1,849	1,461	3,531	3,184

*Less than 0.5%

[a]Totals exceed 100% because most respondents mentioned more than one type of specific description.

TABLE 6--Continued

Specific Description	Proportion Mentioning Each Specific Description												
	First Impression		Non-Psychotic Mental Illness			"Nervous Breakdown"						"Total" Impression	
	All Respondents	Respondents Mentioning Any Specific Description	All Respondents	Respondents Who Believed Mental Illness Included Non-Psychotic Categories		All Respondents		Respondents Who Classified Nervous Breakdown as Mental Illness		Respondents Who Did Not Classify Nervous Breakdown as Mental Illness		All Respondents	Respondents Mentioning Any Specific Description
				Total	Those Mentioning Any Specific Description	Total	Those Mentioning Any Specific Description	Total	Those Mentioning Any Specific Description	Total	Those Mentioning Any Specific Description		
DETAIL:													
DISORDERED EMOTIONAL TONE													
Irritable, excitable, sensitive, easily upset	12	15	12	15	19	18	22	16	19	19	25	23	26
Unhappy, depressed	9	11	8	10	13	6	7	7	8	5	6	15	16
Worried, fearful, anxious	9	11	11	13	18	9	11	10	12	9	11	20	22
Hostile, aggressive, difficult	7	9	5	6	9	3	4	3	4	3	4	12	13
Withdrawn, introverted, asocial	5	6	4	5	6	5	6	6	8	4	5	10	11
Apathetic, indifferent, inert	4	4	3	4	5	6	8	6	7	6	8	8	9
Defeated, surrendering, hopeless	1	2	1	1	2	5	6	6	7	4	5	4	5
Secretive, self-concealing	1	1	*	1	1	*	*	-	-	*	*	1	1
Outgoing, elated, extroverted	1	1	1	1	1	*	1	1	1	*	*	2	2
Inhibited, repressed, emotionally inaccessible	*	*	*	*	*	*	*	*	*	-	-	1	1
INTELLECTUAL IMPAIRMENT													
Inappropriate, incoherent talk	14	17	4	5	7	2	3	3	4	2	2	17	19
Distracted, absent-minded, forgetful	8	10	6	7	10	4	6	6	7	3	4	14	15
Brooding, preoccupied	5	6	5	6	8	4	5	5	6	2	3	10	11
Obsessive, compulsive	5	6	4	5	7	1	2	2	2	1	1	9	10
Major memory disorders, (amnesia, etc.)	4	4	2	2	2	2	2	2	3	1	1	5	6
Intellectually retarded, uncomprehending	3	3	1	1	2	1	1	1	2	1	1	4	4
Impaired performance, efficiency	2	2	1	1	2	3	3	3	3	3	4	3	4
Complete inability to perform	2	2	1	1	1	7	9	7	9	7	9	5	6

TABLE 5--Continued

Specific Description	Proportion Mentioning Each Specific Description													
	First Impression		Non-Psychotic Mental Illness			"Nervous Breakdown"						"Total" Impression	
				Respondents Who Believed Mental Illness Included Non-Psychotic Categories		All Respondents		Respondents Who Classified Nervous Breakdown as Mental Illness		Respondents Who Did not Classify Nervous Breakdown as Mental Illness			
	All Respondents	Respondents Mentioning Any Specific Description	All Respondents	Total	Those Mentioning Any Specific Description	Total	Those Mentioning Any Specific Description	Total	Those Mentioning Any Specific Description	Total	Those Mentioning Any Specific Description	All Respondents	Respondents Mentioning Any Specific Description
DISTORTION OF REALITY													
Distrust, suspicions, paranoid trends. . . .	5	7	3	3	4	2	3	3	3	1	2	8	9
Hypochondriacal tendencies	5	6	4	5	7	2	3	3	4	2	2	8	9
Inability to accept, face, adjust to reality . .	3	3	3	3	4	3	3	4	5	1	2	6	6
Lack of perspective, impaired judgment . . .	3	3	3	4	6	1	2	2	2	1	1	6	6
Delusions	3	3	*	1	1	*	*	*	*	*	*	3	4
Hallucinations	2	3	*	1	1	*	*	1	1	*	*	3	3
Excessive fantasizing, break with reality . .	1	1	*	*	1	*	*	1	1	*	*	2	2
Lack of self-insight . .	1	1	1	1	1	1	1	1	1	1	1	2	2
Vague and unspecified reality distortion . .	4	5	2	3	4	1	1	1	2	1	1	6	7
DEVIANT EXTERNAL APPEARANCE													
Tense, jumpy, restless, unable to relax	11	14	12	14	19	23	28	23	27	23	30	26	28
Peculiar facial expression	4	5	1	2	2	*	1	1	1	*	*	5	6
Tremors, twitches, tics .	3	3	2	3	4	6	8	5	6	7	9	6	7
Stupors, comas, trances .	2	2	1	1	2	2	3	3	3	2	3	4	5
Peculiarity in posture, walk	1	1	*	*	1	*	*	*	*	*	*	1	2
Neglect of personal appearance	1	1	*	*	*	*	*	*	*	*	*	1	1
Other and vague signs in external appearance . .	2	3	1	1	2	1	1	1	1	1	1	4	4

TABLE 5 --Continued

Specific Description	Proportion Mentioning Each Specific Description											
	First Impression		Non-Psychotic Mental Illness			"Nervous Breakdown"						"Total" Impression	
	All Respondents	Respondents Mentioning Any Specific Description	All Respondents	Respondents Who Believed Mental Illness Included Non-Psychotic Categories		All Respondents		Respondents Who Classified Nervous Breakdown as Mental Illness		Respondents Who Did Not Classify Nervous Breakdown as Mental Illness		All Respondents	Respondents Mentioning Any Specific Description
				Total	Those Mentioning Any Specific Description	Total	Those Mentioning Any Specific Description	Total	Those Mentioning Any Specific Description	Total	Those Mentioning Any Specific Description		
VIOLENT ACTS													
Suicidal tendencies, impulses	4	5	1	1	2	2	3	3	4	1	2	6	6
Homicidal acts, tendencies	4	5	*	*	1	1	1	1	1	*	*	4	5
Violent sex crimes	1	1	*	*	1	*	*	*	*	-	-	1	1
Violence against people, other or unspecified . .	5	6	1	1	1	1	1	1	1	*	1	6	6
Destructiveness, violence against property	1	2	*	1	1	*	*	*	*	*	*	2	2
Other and unspecified violence	3	4	*	*	*	1	1	2	2	*	1	4	5
VIOLENT, EXTREME EXPRESSION													
Senseless, excessive weeping	5	6	4	5	7	14	17	14	17	13	17	13	15
Raging, screaming, tantrums	3	4	2	2	3	3	3	3	4	3	3	5	6
Senseless, excessive laughter	2	3	1	1	1	1	2	2	2	1	2	3	4
Noisy, loud, boisterous .	1	1	*	*	1	*	*	1	1	*	*	2	2
Hysterics, unspecified . .	1	1	1	1	1	3	3	3	4	2	2	3	3

TABLE [illegible] Continued

Specific Description	Proportion Mentioning Each Specific Description											
	First Impression		Non-Psychotic Mental Illness			"Nervous Breakdown"						"Total" Impression	
	All Respondents	Respondents Mentioning Any Specific Description	All Respondents	Respondents Who Believed Mental Illness Included Non-psychotic Categories		All Respondents		Respondents Who Classified Nervous Breakdown as Mental Illness		Respondents Who Did Not Classify Nervous Breakdown as Mental Illness		All Respondents	Respondents Mentioning Any Specific Description
				Total	Those Mentioning Any Specific Description	Total	Those Mentioning Any Specific Description	Total	Those Mentioning Any Specific Description	Total	Those Mentioning Any Specific Description		
DISORDERED SELF-IMAGE, CHARACTER TRAITS													
Critical, dissatisfied, complaining	3	4	3	3	5	2	2	2	3	2	2	5	6
Egocentric, self-centered, demanding	3	4	3	4	5	2	2	2	3	1	1	6	7
Martyred, self-pitying, feelings of rejection . .	2	2	2	3	3	2	2	2	2	1	2	4	4
Insecure, lacking self-confidence	1	1	1	2	2	1	1	1	1	*	1	2	3
Self-righteous, self-justifying, obstinate	1	1	1	2	2	1	1	1	1	*	*	2	3
Submissive, dependent, indecisive	1	1	1	1	1	1	1	1	1	*	*	2	2
Self-accusatory, self-blaming	*	*	*	1	1	*	*	*	*	*	*	1	1

TABLE 6--Continued

Special Description	Proportion Mentioning Each Specific Description											
	First Impression		Non-Psychotic Mental Illness			"Nervous Breakdown"						"Total" Impression	
	All Respondents	Respondents Mentioning Any Specific Description	All Respondents	Respondents Who Believed Mental Illness Included Non-Psychotic Categories		All Respondents		Respondents Who Classified Nervous Breakdown as Mental Illness		Respondents Who Did Not Classify Nervous Breakdown as Mental Illness		All Respondents	Respondents Mentioning Any Specific Description
				Total	Those Mentioning Any Specific Description	Total	Those Mentioning Any Specific Description	Total	Those Mentioning Any Specific Description	Total	Those Mentioning Any Specific Description		
HEALTH IMPAIRMENT													
Chronic fatigue, exhaustion	3	3	3	3	4	10	12	8	10	11	14	7	8
Loss of weight, appetite	2	2	2	2	3	6	7	6	7	5	7	5	6
Insomnia	2	2	2	3	4	6	8	6	7	7	9	5	6
Headaches	1	1	1	1	1	1	2	1	1	1	2	2	2
Physical malaise, weakness, collapse	1	1	1	1	2	17	21	16	19	19	24	9	10
Other specific psychophysiologic disorders	1	2	1	2	2	4	5	4	5	4	6	5	5
Physical illness, vague	2	2	2	2	3	5	6	5	6	5	7	5	6
SPEECH MANNERISMS, DISORDERS													
Talking to self	3	4	1	1	1	*	*	*	1	*	*	4	4
Verbosity, excessive talking	2	2	1	1	2	1	1	*	1	1	1	3	3
Mutism, refusal to talk	2	2	*	*	1	1	1	1	1	1	1	2	2
Taciturnity, too little talking	1	1	1	1	1	*	1	1	1	*	*	1	1
Other speech disturbances	1	2	1	1	1	1	1	1	1	*	1	2	3

TABLE 2 -Continued

Specific Description	Proportion Mentioning Each Specific Description											
	First Impression		Non-Psychotic Mental Illness			"Nervous Breakdown"						"Total" Impression	
	All Respondents	Respondents Mentioning Any Specific Description	All Respondents	Respondents Who Believed Mental Illness Included Non-Psychotic Categories		All Respondents		Respondents Who Classified Nervous Breakdown as Mental Illness		Respondents Who Did Not Classify Nervous Breakdown as Mental Illness		All Respondents	Respondents Mentioning Any Specific Description
				Total	Those Mentioning Any Specific Description	Total	Those Mentioning Any Specific Description	Total	Those Mentioning Any Specific Description	Total	Those Mentioning Any Specific Description		
EXCEPTIONAL, UNUSUAL BEHAVIOR													
Wandering, running away . .	1	2	*	*	*	*	1	1	1	*	*	2	2
Instances of bizarre behavior	2	2	*	1	1	*	*	*	*	*	*	3	3
Instances of culturally-unacceptable behavior . .	3	4	1	2	2	*	*	1	1	-	-	5	5
ANTI-SOCIAL BEHAVIOR													
Excessive drinking, alcoholism	2	2	2	2	3	1	1	1	1	1	1	4	4
Criminality, delinquency	1	1	*	*	1	*	*	*	*	*	*	2	2
Lying, falsification, misrepresentation	1	1	1	1	1	*	*	*	*	*	*	1	1
Sexual deviancy	1	1	*	*	*	*	*	*	*	*	*	1	1
Drug addiction	*	*	*	*	1	*	*	*	*	*	*	*	1

TABLE 7

SPECIFIC DESCRIPTIONS USED IN DESCRIBING DIFFERENT MENTAL ILLNESS SYNDROMES

Specific Description	Proportion Using Each Specific Description Among Those Rated as Describing Given Syndrome											
	First Impression			Non-Psychotic Mental Illness			"Nervous Breakdown"			"Total" Impression		
	Psychosis Only	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome Only	Psychosis Only	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome Only	Psychosis Only	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome Only	Psychosis Only	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome Only
ALL RESPONDENTS SUMMARY:												
DISORDERED EMOTIONAL TONE	18	52	62	9	51	53	12	56	51	8	68	74
INTELLECTUAL IMPAIRMENT	40	36	30	41	34	26	21	29	24	34	63	41
DISTORTION OF REALITY	20	39	27	14	40	22	11	33	11	17	40	35
DEVIANT EXTERNAL APPEARANCE	18	26	26	15	13	24	15	46	37	13	50	41
VIOLENT ACTS	22	27	2	11	3	2	15	36	2	22	29	4
VIOLENT, EXTREME EXPRESSION	10	13	10	7	6	10	12	26	22	12	28	20
DISORDERED SELF-IMAGE, CHARACTER TRAITS	2	18	20	1	20	16	1	17	8	1	19	29
HEALTH IMPAIRMENT	3	15	18	2	13	15	7	36	51	2	35	37
SPEECH, MANNERISMS, DISORDERS	11	7	4	4	3	4	3	11	3	9	16	6
EXCEPTIONAL, UNUSUAL BEHAVIOR	10	5	2	7	6	2	3	3	1	11	12	2
ANTI-SOCIAL HABITS	4	11	4	3	12	4	1	3	1	4	11	6
NO SPECIFIC DESCRIPTION	23	13	3	26	22	12	51	-	2	28	1	1
Total per cent[a]	181	262	208	140	223	190	152	296	213	161	372	296
Number	1,758	424	1,158	459	64	2,012	652	66	2,517	787	1,582	1,060

[a]Totals exceed 100% because most respondents mentioned more than one type of specific description.

TABLE 7--Continued

Specific Description	Proportion Using Each Specific Description Among Those Rated as Describing Given Syndrome											
	First Impression			Non-Psychotic Mental Illness			"Nervous Breakdown"			"Total" Impression		
	Psychosis Only	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome Only	Psychosis Only	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome Only	Psychosis Only	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome Only	Psychosis Only	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome Only
RESPONDENTS WHO USED SPECIFIC DESCRIPTION												
SUMMARY:												
DISORDERED EMOTIONAL TONE	23	60	64	12	66	60	23	56	52	12	68	75
INTELLECTUAL IMPAIRMENT	51	41	31	56	44	30	42	29	25	47	64	41
DISTORTION OF REALITY	26	44	27	19	52	26	22	33	11	24	40	35
DEVIANT EXTERNAL APPEARANCE	24	29	26	20	18	27	29	46	38	19	50	41
VIOLENT ACTS	29	31	2	16	4	2	30	36	2	31	29	4
VIOLENT, EXTREME EXPRESSION	14	14	10	10	8	11	24	26	23	17	28	20
DISORDERED SELF-IMAGE, CHARACTER TRAITS	3	20	20	1	26	19	2	17	9	2	19	29
HEALTH IMPAIRMENT	4	17	18	3	18	16	14	36	52	3	36	37
SPEECH MANNERISMS, DISORDERS	14	8	4	6	4	5	6	11	3	13	16	6
EXCEPTIONAL, UNUSUAL BEHAVIOR	13	5	2	9	8	2	7	3	1	16	12	2
ANTI-SOCIAL HABITS	5	12	4	4	16	5	3	3	1	5	11	6
Total per cent[a]	206	281	208	156	264	203	202	296	217	189	373	296
Number	1,361	371	1,128	342	50	1,774	321	66	2,475	569	1,566	1,049

[a] Totals exceed 100% because most respondents mentioned more than one type of specific description.

TABLE 7--Continued

Specific Description	Proportion Using Each Specific Description Among Those Rated as Describing Given Syndrome											
	First Impression			Non-Psychotic Mental Illness			"Nervous Breakdown"			"Total" Impression		
	Psychosis Only	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome Only	Psychosis Only	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome Only	Psychosis Only	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome Only	Psychosis Only	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome Only
RESPONDENTS WHO USED SPECIFIC DESCRIPTION												
DETAIL:												
DISORDERED EMOTIONAL TONE												
Irritable, excitable, sensitive, easily upset	5	20	26	2	26	21	5	29	22	4	26	35
Unhappy, depressed	6	20	16	3	22	14	4	11	7	2	18	20
Worried, fearful, anxious	5	21	17	4	26	20	4	14	11	3	21	28
Hostile, aggressive, difficult	5	10	13	2	2	14	2	11	4	3	13	17
Withdrawn, introverted, asocial	4	7	8	2	2	7	3	14	6	2	12	12
Apathetic, indifferent, inert	3	7	6	2	4	5	5	3	8	3	10	10
Defeated, surrendering, hopeless	*	4	3	*	2	2	4	11	6	*	6	6
Secretive, self-concealing	1	*	1	*	*	1	*	-	*	*	1	2
Outgoing, elated, extroverted	1	2	2	*	2	5	1	-	*	1	2	2
Inhibited, repressed, emotionally inaccessible	*	1	*	*	2	*	*	-	*	*	1	1
INTELLECTUAL IMPAIRMENT												
Inappropriate, incoherent talk	29	12	3	22	4	4	16	3	2	34	25	5
Distracted, absent-minded, forgetful	9	10	13	4	2	11	3	6	5	2	17	19
Brooding, preoccupied	3	5	10	1	2	9	1	-	5	2	11	15
Obsessive, compulsive	7	12	5	7	12	8	3	6	1	8	12	8
Major memory disorders, (amnesia, etc.)	8	2	*	16	12	*	16	3	1	11	9	*
Intellectually retarded, uncomprehending	6	2	*	8	2	1	5	6	1	7	7	1
Impaired performance, efficiency	1	4	3	*	2	2	1	-	3	*	4	5
Complete inability to perform	2	4	2	3	2	1	4	9	9	2	7	5

*Less than 0.5%.

TABLE 7--Continued

Specific Description	Proportion Using Each Specific Description Among Those Rated as Describing Given Syndrome											
	First Impression			Non-Psychotic Mental Illness			"Nervous Breakdown"			"Total" Impression		
	Psychosis Only	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome Only	Psychosis Only	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome Only	Psychosis Only	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome Only	Psychosis Only	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome Only
RESPONDENTS WHO USED SPECIFIC DESCRIPTIONS												
DISTORTION OF REALITY												
Distrust, suspicions, paranoid trends	7	12	5	4	8	4	9	11	2	5	12	6
Hypochondriacal tendencies	1	15	11	1	22	7	1	-	3	*	8	14
Inability to accept, face, adjust to reality	2	9	4	2	8	5	4	17	3	5	8	7
Lack of perspective, impaired judgment	1	7	6	*	4	6	*	3	2	*	6	9
Delusions	6	5	*	5	2	*	3	2	*	9	5	*
Hallucinations	5	2	*	3	16	*	4	6	*	5	5	*
Excessive fantasizing, break with reality	2	6	*	3	4	*	3	6	*	3	3	*
Lack of self-insight	2	2	1	*	2	1	*	-	1	1	3	2
Vague and unspecified reality distortion	5	5	4	4	4	4	2	9	1	3	8	6
DEVIANT EXTERNAL APPEARANCE												
Tense, jumpy, restless, unable to relax	7	23	22	2	14	21	12	39	28	4	29	36
Peculiar facial expression	8	2	1	7	2	2	3	-	*	8	8	1
Tremors, twitches, tics	3	4	4	1	2	4	3	11	7	1	8	8
Stupors, comas, trances	4	1	*	7	4	1	12	-	1	5	5	1
Peculiarity in posture, walk	3	*	*	3	2	*	*	-	*	4	2	*
Neglect of personal appearance	1	*	1	*	-	*	*	-	*	1	1	1
Other and vague signs in external appearance	4	2	3	3	2	2	1	6	2	3	6	4

TABLE 7--Continued

Specific Description	Proportion Using Each Specific Description Among Those Rated as Describing Given Syndrome											
	First Impression			Non-Psychotic Mental Illness			"Nervous Breakdown"			"Total" Impression		
	Psychosis Only	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome Only	Psychosis Only	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome Only	Psychosis Only	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome Only	Psychosis Only	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome Only
RESPONDENTS WHO USED SPECIFIC DESCRIPTIONS												
VIOLENT ACTS												
Suicidal tendencies, impulses	6	9	2	2	2	1	9	14	2	7	9	3
Homicidal acts, tendencies	7	8	*	3	2	*	7	6	*	11	7	*
Violent sex crimes	2	3	*	*	-	1	*	-	*	1	2	1
Violence against people, other or unspecified	10	7	*	6	-	1	8	11	*	14	8	1
Destructiveness, violence against property	3	3	*	5	-	*	2	-	*	4	3	*
Other and unspecified violence	6	11	*	1	-	*	8	14	*	6	8	1
VIOLENT, EXTREME EXPRESSION												
Senseless, excessive weeping	6	4	8	5	4	7	10	26	16	7	17	14
Raging, screaming, tantrums	4	5	2	3	-	3	9	-	3	4	8	4
Senseless, excessive laughter	5	2	*	4	4	1	5	-	1	7	5	1
Noisy, loud, boisterous	2	1	*	1	-	1	2	-	*	3	2	1
Hysterics, unspecified	1	2	1	*	-	1	5	-	3	1	4	3
DISORDERED SELF-IMAGE, CHARACTER TRAITS												
Critical, dissatisfied, complaining	1	6	7	*	-	5	*	-	2	*	5	9
Egocentric, self-centered, demanding	1	6	7	1	12	6	1	-	2	1	6	12
Martyred, self-pitying, feelings of rejection	*	4	5	*	4	4	*	11	2	*	3	7
Insecure, lacking self-confidence	*	2	2	*	-	2	*	2	1	1	2	4
Self-righteous, self-justifying, obstinate	1	1	2	*	4	2	*	-	*	*	2	3
Submissive, dependent, indecisive	*	2	2	*	2	2	*	-	1	*	2	3
Self-accusatory, self-blaming	*	*	*	*	-	1	*	2	*	*	1	1

TABLE 7--Continued

Specific Description	Proportion Using Each Specific Description Among Those Rated as Describing Given Syndrome											
	First Impression			Non-Psychotic Mental Illness			"Nervous Breakdown"			"Total" Impression		
	Psychosis Only	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome Only	Psychosis Only	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome Only	Psychosis Only	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome Only	Psychosis Only	Psychosis and Non-Psychotic Syndrome	Non-Psychotic Syndrome Only
RESPONDENTS WHO USED SPECIFIC DESCRIPTIONS												
HEALTH IMPAIRMENT												
Chronic fatigue, exhaution	1	6	5	*	-	5	2	11	12	*	7	10
Loss of weight, appetite	1	3	3	1	4	3	2	2	7	1	6	6
Insomnia	1	3	4	1	4	4	2	3	8	*	6	8
Headaches	*	2	2	*	-	1	*	-	2	*	2	2
Physical malaise, weakness, collapse	1	2	2	*	2	1	8	14	21	1	11	11
Other specific psychophysiologic disorders	1	2	3	*	2	3	1	14	5	1	5	6
Physical illness, vague	1	4	4	*	4	3	1	6	6	*	5	8
SPEECH MANNERISMS, DISORDERS												
Talking to self	6	3	*	3	-	1	2	-	*	7	6	1
Verbosity, excessive talking	3	2	2	1	4	2	2	2	1	4	3	3
Mutism, refusal to talk	3	2	*	*	-	1	2	9	*	3	4	*
Taciturnity, too little talking	1	1	2	*	-	1	*	-	1	*	1	2
Other speech disturbances	2	*	1	1	-	1	*	2	1	2	4	2
EXCEPTIONAL, UNUSUAL BEHAVIOR												
Wandering, running away	3	*	*	2	-	*	5	-	*	5	3	*
Instances of bizarre behavior	4	1	*	5	8	*	2	-	*	6	4	*
Instances of culturally-unacceptable behavior	6	4	2	3	-	2	1	3	*	7	7	2
ANTI-SOCIAL BEHAVIOR												
Excessive drinking, alcoholism	2	7	2	2	8	3	2	3	1	2	5	4
Criminality, delinquency	2	2	1	2	-	1	*	-	*	2	2	1
Lying, falsification, misrepresentation	1	1	1	1	4	3	*	-	*	*	2	1
Sexual deviancy	1	3	1	*	-	1	*	-	*	*	2	1
Drug addiction	*	1	*	*	4	1	*	-	*	*	1	*

TABLE 8

INTERRELATION OF FIRST IMPRESSION OF MENTAL ILLNESS AND VIEW OF "NON-INSANE" MENTAL ILLNESS

View of "Non-Insane" Mental Illness	Proportion of All Respondents with Each View of "Non-Insane" Mental Illness and Final Rating of First Impression of Mental Illness of:			
	Psychosis Only	Non-Psychotic Syndrome Included	Mental Deficiency, Non-Mental Illness or Unable to Describe	Total
"Insanity" only	8	2	*	10
Undecided, don't know	4	2	1	7
"Non-insane," also, with final rating as:				
Psychosis only	9	3	1	13
Psychosis and non-psychotic syndrome .	1	1	*	2
Non-psychotic syndrome only	24	33	1	58
Mental deficiency, non-mental illness or unable to describe	4	4	2	10
Total per cent	50	45	5	100
Number	1,758	1,582	191	3,531

*Less than 0.5%.

TABLE 9

INFLUENCE OF PHYSICAL IMAGERY IN CLASSIFICATION OF "NERVOUS BREAKDOWN"

Physical Elements in Description of "Nervous Breakdown"	Proportion in Each Descriptive Group who Said "Nervous Breakdown" was Mental Illness	
	Description Included Tense-Uncontrolled-Irritability Symptoms	Description Did Not Include Tense-Uncontrolled Irritability Symptons
Overwork-fatigue-exhaustion symptoms described		
Nerve damage referred to	37 (205)[a]	37 (169)
Nerve damage not referred to	44 (694)	44 (588)
No mention of overwork-fatigue-exhaustion symptoms		
Nerve damage referred to	50 (256)	56 (154)
Nerve damage not referred to	54 (804)	58 (491)

[a]The number in parentheses is the number of cases on which the percentage is based.

TABLE 9-1 (p. 1 of 2)

EDUCATION, INFORMATION AND EXPERIENCE DIFFERENCES IN SPONTANEOUS REFERENCES TO PSYCHIATRY[a]

Spontaneous Reference to Psychiatry	Proportion of Respondents in Indicated Group Volunteering Each Type of Reference															
	Educational Attainment						Information Exposure			Contact with Psychiatric Patients			Summary[b]			
	College Graduate and Above	Some College	High School Graduate	Some High School	Grammar School Graduate	Less Than Grammar School Graduate	High Exposure (6 or More Sources)	Middle Exposure (3-5 Sources)	Low Exposure (0-2 Sources)	Non-Institutionalized Patients	Institutionalized Patients Only	None Reported	Highest Involvement	Intermediate Involvement	Lowest Involvement	All Respondents
ALL REFERENCES																
Psychiatrist . .	88	76	68	56	38	20	76	58	31	77	45	44	91	53	18	53
Psychoanalyst, analyst	7	4	3	1	*	*	5	2	*	4	1	1	7	2	-	2
Psychologist . .	15	15	9	5	3	2	13	7	2	12	5	5	26	6	1	6
Doctor specializing in mental illness ("mind" or "mental" doctor)	12	13	15	20	18	17	15	18	16	12	20	15	7	17	14	17
Doctor specializing in nervous illness ("nerve," "head," "brain," doctor)	6	10	11	15	20	18	11	15	16	12	16	14	4	15	16	15
Mental hospital (asylum, institution, sanitorium)	48	50	50	54	53	46	53	53	46	48	54	45	45	51	38	51
No reference to any of above .	4	6	10	11	20	30	5	11	27	7	16	23	2	14	39	15
Total per cent[c]	180	174	166	162	152	133	178	164	138	172	157	147	182	158	126	159

*Less than 0.5%.

[a]"Spontaneous references to psychiatry" are those which occurred in Questions 1-20, except that references to mental hospitals in Q.s 20 and 26-28 are not included.

[b]See Table 56 for a definition of "involvement."

[c]Totals exceed 100% because respondents often used more than one term.

TABLE 9-1--Continued (p. 2 of 2)

Spontaneous Reference to Psychiatry	Proportion of Respondents in Indicated Group Volunteering Each Type of Reference															
	Educational Attainment						Information Exposure			Contact with Psychiatric Patients			Summary[b]			
	College Graduate and Above	Some College	High School Graduate	Some High School	Grammar School Graduate	Less Than Grammar School Graduate	High Exposure (6 or More Sources)	Middle Exposure (3-5 Sources)	Low Exposure (0-2 Sources)	Non-Institutionalized Patients	Institutionalized Patients Only	None Reported	Highest Involvement	Intermediate Involvement	Lowest Involvement	All Respondents
MOST PRECISE REFERENCE																
Psychiatrist.	68	76	68	56	38	20	76	58	31	77	45	44	91	53	18	53
Psychoanalyst, psychologist	2	4	4	2	1	1	4	2	1	2	2	2	5	2	-	2
Specialist in mental or nervous illness.	3	6	11	20	25	27	10	18	23	10	21	18	1	18	26	18
Mental hospital only.	3	8	7	11	16	22	5	11	18	4	16	13	1	13	17	12
No reference to any of above	4	6	10	11	20	30	5	11	27	7	16	23	2	14	39	15
Total per cent	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
TREATMENT CONTEXT OF ALL REFERENCES TO PSYCHIATRIC PERSONS																
Non-psychotic disorders	52	42	44	38	35	22	46	41	27	46	36	31	51	38	18	38
Both non-psychotic and psychotic disorders	27	28	22	19	11	8	30	18	9	28	14	13	35	17	6	17
Psychotic disorders .	6	5	5	6	6	7	5	6	7	5	6	7	4	6	6	6
Family crisis only .	8	11	12	15	12	11	9	13	12	10	12	13	7	12	14	12
No reference to psychiatric persons .	7	14	17	22	36	52	10	22	45	11	32	36	3	27	56	27
Total per cent	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Number	246	360	736	768	675	696	798	1,449	1,284	315	1,931	785	160	3,131	240	3,531

TABLE 9-2 (p. 1 of 3)

EDUCATION, INFORMATION AND EXPERIENCE DIFFERENCES IN KNOWLEDGE OF PSYCHIATRIC PROCEDURES[a]

Knowledge of Psychiatric Procedures	Proportion of Respondents in Indicated Group Giving Each Description of Psychiatric Procedures															
	Educational Attainment						Information Exposure			Contact with Psychiatric Patients			Summary[b]			
	College Graduate and Above	Some College	High School Graduate	Some High School	Grammar School Graduate	Less Than Grammar School Graduate	High Exposure (6 or More Sources)	Middle Exposure (3-5 Sources)	Low Exposure (0-2 Sources)	Non-Institutionalized Patients	Institutionalized Patients Only	None Reported	Highest Involvement	Intermediate Involvement	Lowest Involvement	All Respondents
OBJECTIVE CONTENT																
Has no idea	8	11	16	25	45	54	10	23	50	10	35	38	3	28	63	30
Vague, unclassifiable, evasive answers only . . .	2	6	5	5	4	6	3	6	5	3	5	6	1	6	5	5
Description of conventional medical treatment only .	-	1	2	5	6	9	3	4	6	2	5	4	1	4	7	4
Psychotherapy only																
Vague reference to "talk" . . .	22	23	23	22	15	8	19	22	14	22	16	17	21	19	9	18
Some detail . . .	57	49	45	34	23	18	53	37	21	51	30	30	61	35	10	35
Psychotherapy and physical psychiatric therapies																
Psychotherapy in vague reference to "talk". . . .	3	3	3	3	2	1	4	3	1	4	2	2	4	3	*	3
Psychotherapy had some detail . .	8	6	5	4	3	1	7	3	1	6	3	2	9	3	2	3
Physical psychitric therapies only	*	1	1	2	2	3	1	2	2	2	2	1	-	2	4	2
Total per cent	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

*Less than 0.5%.

[a]Based on Q. 30, and any material specifically referring to psychiatrists in Q.s 16A(2) and 16A(3).

[b]See Table 56 for a definition of "Involvement."

Knowledge of Psychiatric Procedures	Proportion of Respondents in Indicated Group Giving Each Description of Psychiatric Procedures															
	Educational Attainment						Information Exposure			Contact with Psychiatric Patients			Summary[b]			
	College Graduate and Above	Some College	High School Graduate	Some High School	Grammar School Graduate	Less Than Grammar School Graduate	High Exposure (6 or More Sources)	Middle Exposure (3-5 Sources)	Low Exposure (0-2 Sources)	Non-Institutionalized Patients	Institutionalized Patients Only	None Reported	Highest Involvement	Intermediate Involvement	Lowest Involvement	All Respondents
RESPONDENT'S OWN EVALUATION																
Has no idea . . .	8	11	16	25	45	54	10	23	50	10	35	38	3	28	63	30
Explicitly rates own information as inadequate .	3	7	8	7	8	5	6	8	7	6	7	7	3	7	6	7
Explicitly indicates lack of further information with a vague, general or incomplete answer	12	12	16	15	11	9	9	15	12	13	12	13	6	13	9	13
Expresses some doubt or uncertainty about accuracy of own information . .	13	14	17	14	11	11	13	15	11	14	13	14	12	14	11	13
Explicitly rates own information as adequate . .	8	4	4	2	2	1	6	2	2	5	3	2	7	3	1	3
No reference to adequacy of answer	56	52	39	37	23	20	56	37	18	52	30	26	69	35	10	34
Total per cent	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

TABLE 9-2--Continued (p. 3 of 3)

Knowledge of Psychiatric Procedures	Proportion of Respondents in Indicated Group Giving Each Description of Psychiatric Procedures															
	Educational Attainment						Information Exposure			Contact with Psychiatric Patients			Summary[b]			
	College Graduate and Above	Some College	High School Graduate	Some High School	Grammar School Graduate	Less Than Grammar School Graduate	High Exposure (6 or More Sources)	High Exposure (3-5 Sources)	Low Exposure (0-2 Sources)	Non-Institutionalized Patients	Institutionalized Patients Only	None Reported	Highest Involvement	Intermediate Involvement	Lowest Involvement	All Respondents
CONTENT AND EVALUATION																
None . .																
Has no idea	8	11	1[illegible]	25	45	5[illegible]	1[illegible]	23	5[illegible]	1[illegible]	35	3[illegible]	3	2[illegible]	63	3[illegible]
Evasive or erroneous																
Explicitly speculative, uncertain, not further informed	*	5	6	7	7	9	3	6	8	3	6	7	-	6	9	6
Not explicitly inadequate	2	2	1	3	3	6	3	4	3	2	4	3	2	4	3	3
Vague psychotherapy only																
Explicitly speculative, uncertain, not further informed	10	11	15	13	10	6	1[illegible]	14	10	12	12	11	6	12	7	11
Not explicitly inadequate	12	12	8[illegible]	9	5	2	9	8	4	1[illegible]	6	6	15	7	2	7
Some detail on psychotherapy and/or physical therapy																
Explicitly speculative, uncertain .	1[illegible]	17	20	16	13	10	15	18	12	18	14	16	15	16	10	16
Not explicitly speculative, uncertain	50	42	34	27	17	13	50	27	13	45	23	19	59	27	6	27
Total per cent	1[illegible]0	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Number	246	360	7[illegible]6	768	675	696	798	1,449	1,284	[illegible]15	1,931	785	160	3,131	240	3,531

TABLE 9-3 (p. 1 of 4)

EDUCATION, INFORMATION AND EXPERIENCE DIFFERENCES IN CONCEPTIONS OF PSYCHIATRY[a]

Conception of Psychotherapy	Proportion of Respondents in Indicated Group Giving Each Description of Psychotherapy															
	Educational Attainment						Information Exposure			Contact with Psychiatric Patients			Summary[b]			
	College Graduate and Above	Some College	High School Graduate	Some High School	Grammar School Graduate	Less Than Grammar School Graduate	High Exposure (6 or More Sources)	Middle Exposure (3-5 Sources)	Low Exposure (0-2 Sources)	Non-Institutionalized Patients	Institutionalized Patients Only	None Reported	Highest Involvement	Intermediate Involvement	Lowest Involvement	All Respondents
DETAIL																
Emotional, affective	20	16	12	8	5	3	17	9	4	16	7	6	24	9	2	9
Provides emotional support, reassurance, motivation	10	12	6	4	3	2	10	5	2	9	4	3	16	5	1	5
Permits catharsis or relief from verbalizing problems	10	5	6	3	1	1	6	4	2	6	3	3	8	3	1	3
Encourages interpersonal acting out, development of insight . . .	4	1	1	2	1	-	3	1	*	3	1	1	4	1	-	1

*Less than 0.5%.

[a]Based on Q. 30, and any material specifically referring to psychiatrists in Q.s 16A(2) and 16A(3).

[b]See Table 56 for a definition of "Involvement"

TABLE 9-3--Continued (p. 2 of 4)

Conception of Psychotherapy	Proportion of Respondents in Indicated Group Giving Each Description of Psychotherapy															
	Education Attainment						Information Exposure			Contact with Psychiatric Patients			Summary[b]			
	College Graduate and Above	Some College	High School Graduate	Some High School	Grammar School Graduate	Less Than Grammar School Graduate	High Exposure (6 or More Sources)	Middle Exposure (3-5 Sources)	Low Exposure (0-2 Sources)	Non-Institutionalized Patients	Institutionalized Patients Only	None Reported	Highest Involvement	Intermediate Involvement	Lowest Involvement	All Respondents
DETAIL--Continued																
Rational, logical, didactic	47	41	35	26	16	11	42	27	15	39	22	23	49	26	9	26
Reasons, persuades, dissuades: "talks patient out of it," changes his thinking .	19	17	17	13	8	7	19	13	7	17	11	11	16	13	3	12
Advises, guides, instructs: teaches "healthy" modes of thought and/or emotional control	17	16	13	11	7	4	16	11	6	16	9	8	21	10	4	10
Explains, interprets: discusses causes, "makes patient see" real causes of his difficulties .	13	10	7	4	2	1	9	5	2	8	4	4	16	4	2	5

Conception of Psychotherapy	Proportion of Respondents in Indicated Group Giving Each Description of Psychotherapy															
	Education Attainment						Information Exposure			Contact with Psychiatric Patients			Summary[b]			
	College Graduate and Above	Some College	High School Graduate	Some High School	Grammar School Graduate	Less Than Grammar School Graduate	High Exposure (6 or More Sources)	Middle Exposure (3-5 Sources)	Low Exposure (0-2 Sources)	Non-Institutionalized Patients	Institutionalized Patients Only	None Reported	Highest Involvement	Intermediate Involvement	Lowest Involvement	All Respondents
DETAIL--Continued																
Commonsense, practical.	16	11	13	12	10	8	18	11	7	16	11	9	17	12	4	11
Recommends changes in life situation: changing job, divorce, etc. .	9	4	6	3	3	2	7	4	2	6	3	4	7	4	1	4
Recommends patient develop new interests, engage in constructive or distractive activities . .	6	4	4	4	3	2	6	4	2	6	4	2	5	4	2	4
Recommends patient take a vacation to get rest or a change	3	4	4	6	5	3	7	5	3	6	4	4	4	5	1	4
Recommends sensible physical regimen: more sensible diet, etc	2	3	2	2	3	2	3	2	1	3	2	1	4	2	-	2
Vague reference to "talk" only	25	26	26	25	17	9	23	25	15	26	20	19	25	22	9	21
No reference to psychotherapy . . .	10	19	24	37	57	72	17	35	63	17	47	49	5	40	79	41
Total per cent[c]	113	113	110	108	105	103	117	107	104	114	107	106	120	109	103	108

[c]Totals shown are the totals of major categories only. They exceed 100% because a respondent could describe psychotherapy in terms that fit more than one category.

TABLE 9-3--Continued (p. 4 of 4)

Conception of Psychotherapy	Proportion of Respondents in Indicated Group Giving Each Description of Psychotherapy															
	Educational Attainment						Information Exposure			Contact with Psychiatric Patients			Summary[b]			
	College Graduate and Above	Some College	High School Graduate	Some High School	Grammar School Graduate	Less Than Grammar School Graduate	High Exposure (6 or More Sources)	Middle Exposure (3-5 Sources)	Low Exposure ((0-2 Sources)	Non-institutionalized Patients	Institutionalized Patients Only	None Reported	Highest Involvement	Intermediate Involvement	Lowest Involvement	All Respondents
SUMMARY																
Emotional only	10	7	5	5	3	1	7	5	2	7	4	3	11	4	1	4
Emotional as precondition for, preliminary to, rational and/or practical	10	9	7	3	2	2	10	4	2	9	3	3	13	5	1	5
Rational only	31	29	26	21	11	9	28	21	12	28	16	18	32	19	7	19
Rational and practical	8	4	3	3	3	1	6	2	1	4	3	3	6	3	1	3
Practical only	6	6	9	6	7	6	9	8	5	9	7	5	8	7	2	7
Vague reference to "talk" only	25	26	26	25	17	9	23	25	15	26	20	19	25	22	9	21
No reference to psychotherapy	10	19	24	37	57	72	17	35	63	17	47	49	5	40	79	41
Total per cent	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Number	246	880	786	768	675	696	798	1,449	1,284	815	1,931	785	160	3,131	240	3,531

TABLE 9-4

SUMMARY OF EDUCATION, INFORMATION AND EXPERIENCE DIFFERENCES IN KNOWLEDGE OF PSYCHIATRY[a]

Limit of Knowledge about Psychiatry	Proportion of Respondents in Indicated Group with Each Degree of Knowledge															
	Educational Attainment						Information Exposure			Contact with Psychiatric Patients			Summary[b]			
	College Graduate and Above	Some College	High School Graduate	Some High School	Grammar School Graduate	Less Than Grammar School Graduate	High Exposure (6 or More Sources)	Middle Exposure (3-5 Sources)	Low Exposure (0-2 Sources)	Non-Institutionalized Patients	Institutionalized Patients Only	None Reported	Highest Involvement	Intermediate Involvement	Lowest Involvement	All Respondents
No knowledge	3	6	9	14	30	45	5	14	37	4	24	28	-	19	50	20
Field of specialization exists . .	1	4	5	12	16	19	4	10	16	4	13	12	1	11	20	11
Psychiatry is name of field	6	8	9	9	9	5	7	9	8	7	8	8	4	8	5	8
Psychiatry is physical therapy . . .	*	1	1	2	2	3	1	2	2	2	2	1	-	2	4	2
Psychiatry is talk .	25	26	26	25	17	9	23	25	15	26	20	19	25	22	9	21
Psychotherapy is rational, commonsensical	45	39	38	30	21	16	43	31	18	41	26	26	46	29	10	29
Psychotherapy has emotional elements	20	16	12	8	5	3	17	9	4	16	7	6	24	9	2	9
Total per cent	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Number	246	360	786	768	675	696	798	1,449	1,284	815	1,931	785	160	3,131	240	3,531

*Less than 0.5%.

[a]This classification of knowledge is based on a partial cross-tabulation of spontaneous references to psychiatry, shown in Table 9-1, against knowledge of psychiatric procedures, shown in Tables 9-2 and 9-3. The 39 per cent who had apparently no information about psychiatric procedures are subdivided into those who made no spontaneous reference to psychiatry ("No knowledge"), those who referred to practitioners of psychiatry, but not by that term ("Field of specialization exists"), and those who used the term, "psychiatrist" ("Psychiatry is name of field"). The 61 per cent who had some information are classified without regard to their spontaneous usage of terms, with the few who mentioned both physical therapies and psychotherapies, being classified in terms of their references to psychotherapy.

[b]See Table 56 for a definition of "involvement."

TABLE 9-5 (p. 1 of 2)

EDUCATION, INFORMATION AND EXPERIENCE DIFFERENCES IN OPINIONS OF APPROPRIATE TIME FOR PSYCHIATRIC INTERVENTION[a]

Time or Point of Referral to Psychiatrist	Proportion of Respondents in Indicated Group Mentioning Each Point of Referral															
	Educational Attainment						Information Exposure			Contact with Psychiatric Patients			Summary[b]			
	College Graduate and Above	Some College	High School Graduate	Some High School	Grammar School Graduate	Less Than Grammar School Graduate	High Exposure (6 or More Sources)	Middle Exposure (3-5 Sources)	Low Exposure (0-2 Sources)	Non-Institutionalized Patients	Institutionalized Patients Only	None Reported	Highest Involvement	Intermediate Involvement	Lowest Involvement	All Respondents
WITHOUT DELAY																
Before it is serious, general and unspecified	25	19	20	24	25	21	24	23	20	23	23	21	23	22	18	22
At first sign of illness, first occurrence of symptoms or problems	10	8	11	11	12	10	10	11	10	12	11	8	8	11	8	11
When person first realizes he has symptoms or problems .	9	11	13	15	14	15	13	14	13	11	15	12	8	14	9	13
WITH PERSONAL STRAIN																
When symptoms of inner stress occur .	2	3	4	3	2	4	5	4	2	5	3	3	2	4	2	3
When person feels he needs help with, is unable to cope with, his problems.	18	19	11	9	6	4	16	10	6	16	8	7	26	9	4	10

[a] Based on Question 29.

[b] See Table 56 for a definition of "involvement."

TABLE 9-5--Continued (p. 2 of 2)

Time or Point of Referral to Psychiatrist	Proportion of Respondents in Indicated Group Mentioning Each Point of Referral															
	Educational Attainment						Information Exposure			Contact with Psychiatric Patients			Summary[b]			
	College Graduate and Above	Some College	High School Graduate	Some High School	Grammar School Graduate	Less Than Grammar School Graduate	High Exposure (6 or More Sources)	Middle Exposure (3-5 Sources)	Low Exposure (0-2 Sources)	Non-Institutionalized Patients	Institutionalized Patients Only	None Reported	Highest Involvement	Intermediate Involvement	Lowest Involvement	All Respondents
WITH EXTERNAL EFFECTS																
When person's condition is apparent to others	3	5	5	5	6	6	5	6	5	5	5	5	4	5	5	5
When symptoms manifest in external behavior occur . .	7	8	7	6	5	6	7	6	6	6	6	7	9	7	8	7
IN DUE COURSE																
When help of family and friends proves ineffective	6	3	4	3	2	1	3	3	3	4	3	3	3	3	1	3
When help of physician proves ineffective	4	5	5	3	3	2	4	4	3	4	4	3	4	3	2	3
When physician advises, decides it is necessary . . .	6	6	8	6	5	4	6	6	5	6	5	7	6	6	5	6
When all else fails, as a last resort .	3	2	2	1	1	2	2	2	2	2	2	1	4	2	2	2
Not unless it is serious, general and unspecified .	3	4	3	4	5	5	2	4	5	1	4	4	2	4	4	4
NEVER.	1	2	3	3	2	3	1	2	3	2	2	4	-	2	6	2
DON'T KNOW . . .	3	5	4	7	12	17	2	5	17	3	8	15	1	8	26	9
Total per cent	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Number	246	360	786	768	675	696	798	1,449	1,284	815	1,931	785	160	3,131	240	3,531

TABLE 9-6

REASONS ASCRIBED TO OTHERS FOR NOT SEEKING NEEDED PSYCHIATRIC TREATMENT[a]

Reason for Not Seeking Needed Psychiatric Treatment	Proportion of Indicated Group Mentioning Each Reason			
	All Respondents		Respondents Perceiving Unmet Needs	
	All Reasons Mentioned	Most Serious Reason Mentioned	All Reasons Mentioned	Most Serious Reason Mentioned
Lack of essential information	12	6	43	21
Unaware of their need	9	5	32	17
Unaware of what psychiatry is or does	3	1	9	3
Unaware of available psychiatric facilities	*	*	2	1
Lack of information, vague and unspecified	1	*	2	1
Objective difficulties in way of treatment	9	4	33	14
Therapy is expensive	8	3	30	12
Psychiatrists are unavailable	1	1	4	2
Therapy is long, time-consuming	*	*	1	*
Resistance, opposition to psychiatry	18	18	65	65
Won't admit, resist, recognizing their need, general	5	5	17	17
Believe seeking psychiatric treatment would define them as "crazy," "insane"	3	3	10	10
Believe in self-reliance, solving own problems	1	1	2	2
Believe stigma attaches to seeking psychiatric treatment, other or unspecified	3	3	11	11
Afraid of diagnosis or treatment; fear being found seriously ill, hospitalized	2	2	7	7
Don't want (afraid to) face themselves, learn truth about self	2	2	6	6
Don't want to (afraid to) reveal themselves to others	1	1	4	4
Don't want to (afraid to) lose or give up symptomatic behavior, gratifications	1	1	3	3
Negligence, procrastination	2	2	5	5
Fear, shame, embarrassment, vague and unspecified	1	1	4	4
Lack confidence in psychiatry	4	4	14	14
No unmet needs perceived	72	72	-	-
Total per cent[b]	111	100	141	100
Number	3,531	3,531	989	989

*Less than 0.5%.

[a]Based on question 32A.

[b]Totals shown here are the totals of the major categories only. Since a respondent could mention more than one type of reason within a major category as well as more than one major category of reasons, totals of its sub-categories are not, in general, the same as the percentage shown for a category as a whole, and totals of the major categories exceed 100% for "all reasons mentioned."

TABLE 9-7

EDUCATIONAL, INFORMATION AND EXPERIENCE DIFFERENCES IN PERSONAL INTEREST IN CONSULTING A PSYCHIATRIST[a]

Desire to Consult a Psychiatrist	Proportion of Respondents in Indicated Group Expressing Each Degree of Interest															
	Educational Attainment						Information Exposure			Contact with Psychiatric Patients			Summary			
	College Graduate and Above	Some College	High School Graduate	Some High School	Grammar School Graduate	Less Than Grammar School Graduate	High Exposure (6 or More Sources)	Middle Exposure (3-5 Sources)	Low Exposure (0-2 Sources)	Non-Institutionalized Patients	Institutionalized Patients Only	None Reported	Highest Involvement	Intermediate Involvement	Lowest Involvement	All Respondents
Interest																
Admission of therapeutic need																
Present therapeutic interest	10	9	9	12	6	6	15	9	4	14	8	5	18	9	3	9
Past therapeutic interest	2	2	2	1	1	1	2	1	1	5	*	*	4	1	-	1
Denial of need																
Precautionary interest	4	6	3	3	2	2	4	3	2	5	3	2	6	3	*	3
Didactic interest	2	3	2	1	1	1	2	2	1	1	2	1	2	2	1	2
No Interest (denial of need)																
Contingent willingness	27	24	26	25	26	20	31	25	21	28	25	20	27	25	15	25
Pregmatic rejection	36	33	37	36	37	36	29	39	37	28	38	38	25	36	35	36
Positive opposition beyond simple lack of need	15	19	18	18	22	24	14	17	26	16	19	26	14	20	31	20
Don't know, unclassifiable	4	4	3	4	5	10	3	4	8	3	5	8	4	4	15	4
Total per cent	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Number	246	360	786	768	675	696	798	1,449	1,284	815	1,931	785	160	3,131	240	3,531

*Less than 0.5%.

[a]Based on questions 33, 33A and 33B.

TABLE 9-8

REASONS FOR OPPOSITION TO CONSULTING PSYCHIATRISTS[a]

Reasons for Opposition to Consulting Psychiatrists	Proportion Mentioning Each Reason	
	Respondents Who Believe Others to Be Opposed	Respondents Opposed Themselves
Threat to Self-Image		
Won't admit, resist, recognizing their need . .	28	-
Believe seeking psychiatric treatment would define them as "crazy," "insane".	16	12
Believe in self reliance, solving own problems.	3	25
Believe stigma attaches to seeking psychiatric treatment, other and unspecified	17	3
Afraid of diagnosis or treatment; fear being found seriously ill, hospitalized	12	3
Don't want to (afraid to) face themselves, learn truth about self	10	-
Don't want to (afraid to) reveal themselves . .	7	3
Don't want to (afraid to) lose or give up symptomatic behavior, gratifications	5	1
Fear, shame, embarrassment, negligence, vague and unspecified	16	10
Criticism of Psychiatry		
Psychiatry is suspect, questionable, dubious	22[b]	
Too unfamiliar to have confidence in it . .		11
Too expensive for what it does		8
Sometimes harmful, dishonest, etc.		7
Psychiatry is unnecessary: other sources of aid are sufficient		15
Psychiatry is entirely unsound: invalid, ineffective, useless		19
Total per cent[c]	136	117
SUMMARY		
Self-image only	78	46
Psychiatry only	13	46
Both	9	8
Total per cent	100	100
Number	631	697
Proportion of total population in group	18	20

[a]Based on Questions 32A and 33B.

[b]Detail not available.

[c]Totals exceed 100% because some respondents mentioned more than one reason.

TABLE 9-9

EXPLICIT EVALUATIONS OF PSYCHIATRY[a]

Comment on Psychiatry	Proportion of Respondents Making Each Comment	
	All Comments Made	Most Extreme Comment Made
Psychiatry is invalid, ineffective, useless	7	7
Psychiatry is dishonest, a deliberate fraud or racket	2	2
Psychiatry is based on incorrect theories of human behavior	1	1
Psychiatry is just talk, doesn't give treatment	1	1
Psychiatry can't help anyone, other and unspecified	4	4
Psychiatry is unnecessary	4	3
Others (physicians, friends) offer adequate and/or equivalent aid	3	2
Religion offers adequate and/or equivalent aid	1	1
Psychiatry is personally inacceptable	15	13
People should be self-reliant, can and should solve own problems	5	4
Accepting treatment would define person as psychotic, insane	3	2
Accepting treatment would damage self-conception, other	3	3
Treatment is personally distasteful, vague and unspecified	4	4
Psychiatry is suspect, dubious, questionable	12	6
Psychiatry contains charlatans: many practitioners unethical	4	3
Psychiatry is too expensive for what it does	3	2
Psychiatry is too unfamiliar to have confidence in it	3	2
Treatment may create or intensify problems	2	1
Psychiatry is (partly) a fad	1	*
Psychiatry is admirable, praisworthy	2	2
No evaluative references to psychiatry	69	69
Total per cent	109	100
Number	3,531	3,531

[a]Based on all comments made in the course of the interview.

*Less than 0.5%.

TABLE 9-10 (p. 1 of 3)

SELECTED COMPONENTS IN ATTITUDES TOWARD PSYCHIATRY

Aspect of Attitude toward Psychiatry	Proportion of Respondents in Indicated Attitude Group with Each View of Psychiatry					
	Completely Opposed	Strongly Opposed	Opposed	Implicitly Rejecting	Implicitly Accepting	Approving. Enthusiastic
SPONTANEOUS REFERENCES						
Most precise term used						
Psychiatrist	8	44	46	46	69	82
Psychoanalyst, psychologist	2	1	2	2	3	3
Specialist in nervous or mental illness	12	19	18	22	13	9
Mental hospital	31	14	14	14	8	4
None	47	22	20	16	7	2
Total per cent	100	100	100	100	100	100
Per cent of those referring to psychiatric persons who used the term psychiatrist	a	68	70	65	81	87
Context of references to psychiatric persons						
Non-psychotic disorders.	8	29	33	38	44	44
Both non-psychotic and psychotic disorders	3	9	13	13	27	36
Psychotic disorders	4	9	6	7	5	8
Family crisis only	7	17	14	13	10	6
No reference to persons.	78	36	34	29	14	6
Total per cent	100	100	100	100	100	100
Per cent of those referring to psychiatric persons who cited them for non-psychotic disorders.	a	59	70	72	83	85
Point of use of psychiatric persons in family crisis						
First step	4	9	13	16	23	33
Second step	5	18	26	27	35	39
Third step	1	14	13	9	13	8
No reference to use	90	59	48	48	29	20
Total per cent	100	100	100	100	100	100
Per cent of those mentioning use who mentioned it as first step.	a	21	25	31	33	41
KNOWLEDGE						
Specificity						
None	62	39	45	46	25	14
Vague	24	25	17	17	19	22
Specific: Speculative	4	13	14	16	18	20
Non-speculative	10	23	24	21	38	44
Total per cent	100	100	100	100	100	100
Per cent of those with specific knowledge who were non-speculative	a	63	62	57	69	71
Limit						
No knowledge	48	21	27	24	10	3
Field of specialization exists	11	12	11	14	7	2
Psychiatry is name of field	3	6	7	9	8	9
Psychiatry is physical therapy	-	1	1	2	2	5
Psychiatry is talk	24	26	19	19	23	22
Psychotherapy is rational, commensensical	11	26	27	26	37	34
Psychotherapy has emotional elements	3	8	8	6	13	25
Total per cent	100	100	100	100	100	100
Per cent of those with specific knowledge of psychotherapy who mentioned emotional elements	a	23	23	18	27	42

[a] Too few cases to report a percentage

TABLE 9-10--Continued (p. 2 of 3)

Aspect of Attitude toward Psychiatry	Proportion of Respondents in Indicated Attitude Group with Each View of Psychiatry					
	Completely Opposed	Strongly Opposed	Opposed	Implicitly Rejecting	Implicitly Accepting	Approving, Enthusiastic
APPROPRIATE TIME						
Without delay	-	32	35	53	52	63
With personal strain	-	10	12	11	17	17
With external effects	-	9	10	12	14	9
In due course	-	35	30	14	13	8
Never	84	3	1	-	-	-
Don't know	16	11	12	10	4	3
Total per cent	100	100	100	100	100	100
RELEVANCE						
Nature of contacts						
Knew non-institutionalized patient who was:						
Helped	-	11	13	-	36	56
Don't know whether helped	2	2	2	3	3	-
Not helped because of:						
Nature of problem	2	2	1	1	2	-
Behavior of patient	2	2	1	1	2	2
Don't know why	4	3	2	1	1	3
Particular psychiatrist	1	1	1	*	*	-
Nature of psychiatry	5	5	1	-	-	-
Did not know non-institutionalized patient.	84	74	79	94	56	39
Total per cent	100	100	100	100	100	100
Per cent of those knowing who said it helped.	a	43	61	-	83	90
Per cent of those saying "not helped" who blamed problem or patient	a	32	36	60	72	a
Awareness of needs						
Knew someone who would benefit from treatment but deterred by:						
Lack of information	-	3	4	-	16	12
Lack of means	-	1	4	-	11	9
Resistance, hostility	-	13	17	-	42	41
Did not know anyone who would benefit	100	83	75	100	31	38
Total per cent	100	100	100	100	100	100
Personal interest						
Therapeutic						
Present	-	2	5	-	23	19
Past	-	*	*	-	4	14
Precautionary	-	1	1	-	9	8
Didactic	-	-	1	-	4	2
None: Future contingent willingness	-	11	16	31	27	33
Pragmatic rejection	9	7	13	59	30	23
Positive opposition	91	78	61	-	-	-
Unclassifiable, don't know	-	1	3	10	3	1
Total per cent	100	100	100	100	100	100

*Less than 0.5%.

TABLE 9-10--Continued (p. 3 of 3)

Aspect of Attitude toward Psychiatry	Proportion of Respondents in Indicated Attitude Group with Each View of Psychiatry					
	Completely Opposed	Strongly Opposed	Opposed	Implicitly Rejecting	Implicitly Accepting	Approving Enthusiastic
EVALUATIONS OF PSYCHIATRY						
All comments						
Invalid	100	63	-	-	-	-
Unnecessary	18	44	-	-	-	-
Unacceptable	22	19	69	-	-	-
Questionable	18	20	39	-	-	-
Admirable	-	1	1	-	-	100
None	-	-	-	100	100	-
Total per cent[b]	158	147	109	100	100	100
Least favorable comment						
Invalid	100	63	-	-	-	-
Unnecessary	-	37	-	-	-	-
Unacceptable	-	-	69	-	-	-
Questionable	-	-	31	-	-	-
Admirable	-	-	-	-	-	100
None	-	-	-	100	100	-
Total per cent	100	100	100	100	100	100
Number	97	240	691	1,370	1,069	64

[b] Totals exceed 100% because respondents could be classified in more than one category.

TABLE 9-11

EDUCATION, INFORMATION AND EXPERIENCE DIFFERENCES IN ATTITUDES TOWARD PSYCHIATRY

Attitude toward Psychiatry	Proportion of Respondents in Indicated Group with Each Attitude toward Psychiatry															
	Educational Attainment						Information Exposure			Contact with Psychiatric Patients			Summary			
	College Graduate and Above	Some College	High School Graduate	Some High School	Grammar School Graduate	Less Than Grammar School Graduate	High Exposure (6 or More Sources)	Middle Exposure (3-5 Sources)	Low Exposure (0-2 Sources)	Non-Institutionalized Patients	Institutionalized Patients Only	None Reported	Highest Involvement	Intermediate Involvement	Lowest Involvement	All Respondents
DETAIL																
Psychiatry is invalid: completely opposed.	2	3	3	3	3	3	1	2	4	2	2	5	*	3	7	3
strongly opposed.	7	8	4	4	3	3	4	4	4	5	4	4	7	4	4	4
Psychiatry is unnecessary: strongly opposed.	2	3	2	2	3	3	1	3	3	2	3	3	2	3	3	3
Psychiatry is unacceptable: opposed	11	12	11	13	16	17	12	12	17	12	13	16	11	13	20	13
Psychiatry is suspect: opposed.	5	6	5	6	6	7	5	6	7	6	6	6	7	6	7	6
No comments:																
implicitly rejecting	23	28	35	40	46	45	23	40	47	11	46	50	5	39	49	39
implicitly accepting	45	38	38	30	21	21	51	31	17	57	25	15	63	30	10	30
Psychiatry is admirable: approving..	5	2	2	2	2	1	3	2	1	5	1	1	5	2	*	2
Total per cent	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
SUMMARY																
Overtly opposed . .	27	32	25	28	31	33	23	27	35	27	28	34	27	29	41	29
Implicitly rejecting	23	28	35	40	46	45	23	40	47	11	46	50	5	39	49	39
Implicitly accepting or overtly approving	50	40	40	32	23	22	54	33	18	62	26	16	68	32	10	32
Total per cent	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Number . . .	246	360	786	768	675	696	798	1,449	1,254	815	1,931	785	160	3,131	240	3,531

*Less than 0.5%.

TABLE 9-12 (p. 1 of 2)

INFLUENCE OF ATTITUDES TOWARD MENTAL ILLNESS AND TOWARD HUMAN BEHAVIOR ON ATTITUDES TOWARD PSYCHIATRY

Related Attitude	Distribution of Attitudes toward Psychiatry among All Respondents with Indicated View					Proportion Accepting Psychiatry among Respondents with Indicated View and with	
	Overtly Hostile	Implicitly Rejecting	Implicitly Accepting or Overtly Approving	Total		Concrete Perceptions Consistently Extending through Neurosis	Concrete Perceptions Not Consistently Extending through Neurosis
				Per cent	Number		
CONCEPTIONS OF MENTAL ILLNESS							
Concrete perceptions[a]							
Consistently extended through personality disorders	19	21	60	100	126		
Consistently extended through neurosis	24	31	45	100	289		
Limited to psychosis generally	28	39	33	100	628		
Limited to violent psychosis	31	38	31	100	1,369		
No apparent perception	33	46	21	100	721		
General usage							
Consistent non-psychotic	27	33	40	100	998	61 (185)[b]	35 (813)
Inconsistent non-psychotic	29	39	32	100	1,644	40 (163)	31 (1,481)
Inconsistent psychotic	30	48	22	100	548	28 (52)	21 (496)
Consistent psychotic	34	43	23	100	239	[c] (12)	22 (227)
None	38	51	11	100	102	[c] (3)	10 (99)
Descriptive criteria							
Emotional-functional deviancy	27	35	38	100	1,666	52 (331)	34 (1,335)
General (unspecified) deviancy	31	44	25	100	884	42 (26)	25 (858)
Cognitive-control deviancy	32	40	28	100	981	34 (58)	28 (923)
Relation to volitional defects							
Volitional defect is mental illness	28	35	37	100	924	53 (147)	34 (777)
No explicit or consistent position on volitional defects	29	40	31	100	2,026	48 (235)	29 (1,791)
Volitional defect is not mental illness	32	41	27	100	581	40 (33)	26 (548)

[a] For clarity of presentation, this table omits a residual group not clearly classifiable for this attitude dimension.

[b] The number in parentheses is the number of cases on which the percentage is based.

[c] Too few cases to report a percentage.

TABLE 9-12--Continued (p. 2 of 2)

Related Attitude	Distribution of Attitudes toward Psychiatry among All Respondents with Indicated View					Proportion Accepting Psychiatry among Respondents with Indicated View and with	
	Overtly Hostile	Implicitly Rejecting	Implicitly Accepting or Overtly Approving	Total		Concrete Perceptions Consistently Extending through Neurosis	Concrete Perceptions Not Consistently Extending through Neurosis
				Per cent	Number		
APPROACHES TO HUMAN BEHAVIOR							
Frequency of psychodynamic explanations							
Used three or more times	27	26	47	100	282	75 (56)	40 (226)
Used twice	29	34	37	100	623	60 (63)	35 (560)
Used once	2[illegible]	3[illegible]	33	100	1,160	47 (141)	31 (1,019)
Never used	30	44	26	100	1,466	37 (155)	25 (1,311)
Emphasis on rational self-control							
None	23	40	37	100	656	60 (108)	33 (548)
Little	27	37	36	100	300	47 (38)	35 (262)
Moderate	30	39	31	100	1,647	49 (185)	29 (1,462)
Great	33	39	28	100	928	37 (84)	27 (844)
Volunteered situations for which psychiatry is relevant[a]							
Both non- or pre-psychotic and psychotic disorders	19	30	51	100	617	66 (137)	47 (480)
Non- or pre-psychotic disorders only	23	39	38	100	1,323	50 (153)	[illegible]6 (1,170)
Ambiguous disorders only	34	40	26	100	427	43 (30)	[illegible]5 (397)
Psychotic disorders only	31	43	26	100	213	c (15)	25 (198)
FEAR OF PSYCHOSIS							
Dangerousness of the "insane"[a]							
Generally not dangerous	29	33	38	100	1,490	56 (198)	35 (1,292)
Generally dangerous	29	43	28	100	1,853	44 (200)	27 (1,653)
Prognosis for "insanity"[a]							
Can generally recover completely							
And most do	24	31	45	100	525	59 (76)	42 (449)
But most do not	29	35	36	100	1,009	51 (144)	32 (865)
Can generally get better (but not recover completely)							
And most do	28	40	32	100	305	55 (31)	30 (274)
But most do not	29	40	31	100	1,150	46 (126)	28 (1,024)
Generally cannot even get better	35	44	21	100	453	28 (35)	21 (418)
Reaction to recovered former patient[a]							
Normal behavior, no difference	25	39	36	100	1,274	53 (154)	34 (1,120)
Care, consideration	29	37	34	100	634	49 (79)	32 (555)
Dubiousness, discomfort	30	35	35	100	365	53 (45)	32 (320)
Fear	31	41	28	100	931	45 (108)	26 (821)
Rejection, avoidance	43	38	19	100	131	c (11)	19 (120)

TABLE 9-13 (p. 1 of 3)

EDUCATION, INFORMATION AND EXPERIENCE DIFFERENCES IN TOTAL ORIENTATIONS TOWARD HUMAN BEHAVIOR AND MENTAL ILLNESS

Orientation toward Human Behavior	Proportion of Respondents in Indicated Group with Each Orientation toward Human Behavior															
	Educational Attainment						Information Exposure			Contact with Psychiatric Patients			Summary			
	College Graduate and Above	Some College	High School Graduate	Some High School	Grammar School Graduate	Less Than Grammar School Graduate	High Exposure (6 or More Sources)	Middle Exposure (3-5 Sources)	Low Exposure (0-2 Sources)	Non-Institutionalized Patients	Institutionalized Patients Only	None Reported	Highest Involvement	Intermediate Involvement	Lowest Involvement	All Respondents
Degree of Psychological Orientation[a]																
8 (Most) .	2	1	*	-	-	-	1	-	-	1	*	-	3	*	-	*
7	5	4	2	*	*	-	4	1	*	4	1	*	9	1	-	1
6	9	9	6	2	1	1	7	4	2	6	3	4	14	3	1	4
5	22	14	10	8	5	3	15	8	5	14	7	7	26	8	5	9
4	22	20	19	17	12	10	21	16	12	21	15	12	19	16	7	16
3	21	21	23	23	22	17	21	24	18	20	23	25	14	23	12	21
2	10	18	22	23	26	26	16	24	26	18	23	25	8	23	24	22
1	8	10	12	19	23	27	11	16	24	12	19	21	5	18	26	18
0 (Least).	1	3	6	8	11	16	4	7	13	4	9	13	2	8	25	9
Total per cent	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Degree of Rational Orientation[a]																
8 (Most) .	-	-	-	*	*	*	*	*	*	-	*	*	-	*	*	*
7	-	-	1	1	2	3	1	1	3	*	1	2	-	1	5	1
6	1	1	3	3	7	10	1	4	8	2	6	7	1	5	13	5
5	4	7	10	10	15	19	7	10	16	7	13	15	3	12	19	12
4	8	13	17	21	22	23	12	20	23	15	20	20	7	19	24	19
3	16	24	24	27	26	23	22	24	25	21	25	26	12	24	21	24
2	28	23	22	24	18	15	26	23	16	24	20	18	19	21	10	21
1	24	20	16	11	8	6	19	13	7	19	11	8	32	12	6	12
0 (Least).	19	12	7	3	2	1	12	5	2	12	4	4	26	6	2	6
Total per cent	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

*Less than 0.5%.

[a]The full definition of each of these scores can be found in a note at the end of the table.

TABLE 9-13--Continued (p. 2 of 3)

Orientation toward Human Behavior	Proportion of Respondents in Indicated Group with Each Orientation toward Human Behavior															
	Educational Attainment						Information Exposure			Contact with Psychiatric Patients			Summary			
	College Graduate and Above	Some College	High School Graduate	Some High School	Grammar School Graduate	Less Than Grammar School Graduate	High Exposure (6 or More Sources)	Middle Exposure (3-5 Sources)	Low Exposure (0-2 Sources)	Non-Institutionalized Patients	Institutionalized Patients Only	None Reported	Highest Involvement	Intermediate Involvement	Lowest Involvement	All Respondents
Net Degree of Psychological orientation																
8 (Host) .	2	1	*	-	-	-	1	-	-	1	*	-	3	*	-	*
7	4	3	2	-	*	-	3	1	*	3	1	*	5	1	-	1
6	4	5	2	1	1	*	4	1	1	4	1	1	11	2	*	2
5	10	6	5	2	1	1	6	3	1	6	2	2	12	3	1	3
4	10	7	6	5	2	1	8	4	3	7	4	3	13	4	2	5
3	17	10	9	7	6	3	11	8	4	11	6	6	16	7	5	7
2	11	13	11	10	6	7	13	9	7	12	9	7	14	9	5	9
1	15	14	13	13	12	9	12	15	10	12	13	11	6	13	6	12
0	9	10	11	12	13	9	12	12	10	10	12	10	6	12	7	12
-1	6	13	11	15	13	14	11	13	13	11	13	12	6	13	10	13
-2	4	5	11	13	14	13	6	12	14	9	12	14	2	11	15	11
-3	4	7	7	9	12	13	5	9	12	6	9	11	2	9	12	9
-4	3	4	7	8	9	12	5	7	11	5	9	10	2	8	14	8
-5	1	2	2	2	6	10	2	3	7	2	5	6	2	4	11	4
-6	-	*	2	2	4	6	1	2	5	1	3	5	-	3	8	3
-7	-	-	1	1	1	2	*	1	2	*	1	2	-	1	4	1
-8 (Least).	-	-	-	*	*	*	*	*	*	-	*	*	-	*	*	*
Total per cent	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Number	246	360	786	768	675	696	798	1,449	1,264	815	1,931	785	160	3,131	240	3,531

The items entering into the two basic scores and the weights assigned them are shown in detail below. The "Net Degree of Psychological Orientation" is defined as the "Psychological Orientation Score" minus the "Rational Orientation Score."

Item	Weight Assigned in Score of: Psychological Orientation	Rational Orientation
Approaches to Human Behavior		
(1) Use of psychodynamic explanations		
Used to explain two or more examples	1	0
Used to explain one example	0	0
Used to explain no examples	0	1
(2) Emphasis on rational self-control in modify-human behavior		
None	1	0
Little	1	0
Moderate	0	0
Great	0	1
Conceptions of Mental Illness		
(3) General usage		
Consistent non-psychotic	1	0
Inconsistent non-psychotic	0	0
Inconsistent psychotic	0	1
Consistent psychotic	0	1
None	0	0
(4) Descriptive criteria		
Emotional-functional deviancy	1	0
Cognitive-control deviancy	0	1
General deviancy	0	0
(5) Concrete perceptions		
Consistently extended through neurosis	1	0
Limited to psychosis generally	0	0
Limited to violent psychosis	0	1
No concrete perception	0	1
Unclassifiable	0	0
Fear of Psychosis		
(6) Dangerousness of the "insane"		
Generally not dangerous	1	0
Generally dangerous	0	1
Unclassifiable	0	0
(7) Prognosis for "insanity"		
Can generally recover completely	1	0
Can generally get better but not recover completely	0	0
Generally cannot even get better	0	1
Unclassifiable	0	0
(8) Reaction to recovered former patient		
Normal behavior, no difference	1	0
Care, consideration	0	0
Dubiousness, discomfort	0	0
Fear	0	1
Rejection, avoidance	0	1
Unclassifiable	0	0

TABLE 9-14

POSSIBLE DETERRANTS TO THE USE OF PSYCHIATRY IN RELATION TO KNOWLEDGE OF PSYCHIATRIC PROCEDURES[a]

Possible Deterrant to Use of Psychiatry	Proportion of Respondents in Indicated Knowledge Group Referring to Each Possible Deterrant							
	No Knowledge	Field Exists	Psychiatry Is Name of Field	Psychiatry Is Physical Therapy	Psychiatry Is Talk	Psychotherapy Is Rational	Psychotherapy Is Emotional	Total Respondents
ALL RESPONDENTS								
Direct limitations	9	15	18	25	26	31	43	24
High cost of psychiatric treatment	(6)	(8)	(9)	(14)	(12)	(16)	(22)	(12)
Shortage, unavailability, of psychiatrists	(1)	(3)	(2)	(3)	(3)	(3)	(4)	(3)
Social disapproval	(1)	(2)	(5)	(8)	(6)	(9)	(13)	(6)
Undependable professional standards	(2)	(4)	(7)	(8)	(9)	(11)	(15)	(8)
Indirect by delegation to physician	24	30	36	32	38	34	38	33
None mentioned	69	59	54	52	48	48	37	53
Total per cent[b]	102	104	108	109	112	113	118	110
Number	719	382	277	63	736	1,037	317	3,531
RESPONDENTS WHO MENTIONED DIRECT LIMITATIONS								
High cost of psychiatric treatment	67	54	51	c	47	53	52	52
Shortage, unavailability, of psychiatrists	8	20	10		11	9	9	11
Social disapproval	12	12	27		23	28	30	25
Undependable professional standards	18	27	37		35	35	35	33
Total per cent[b]	105	113	125		116	125	126	121
Number	66	59	51	16	190	325	136	843

[a]Based on all relevant volunteered remarks throughout the interview.

[b]Totals exceed 100% because some respondents mentioned more than one type of factor.

[c]Too few cases to report percentages.

TABLE 10

INCONSISTENCIES IN FIRST IMPRESSIONS OF MENTAL ILLNESS, AND VIEWS OF "NON-INSANE" MENTAL ILLNESS AND "NERVOUS BREAKDOWNS"

Type of Inconsistency	Proportion in Each Group
Explicitly self-contradictory	
Referred to "nervous conditions" as category of mental illness, but did not classify "nervous breakdown" as mental illness . . .	16
Volunteered term "nervous breakdown" as category of mental illness, then did not classify "nervous breakdown" as mental illness	2
Other self-contradictory use of terms	1
Described same syndrome under "nervous breakdown" and mental illness but did not classify "nervous breakdown" as mental illness .	7
Inconsistent with technical criteria	
Included "non-insane" within mental illness, and described "nervous breakdown" in non-psychotic terms, but did not classify it as mental illness	31
Described "nervous breakdown" in psychotic terms but did not classify it as mental illness	7
Did not include "non-insane" within mental illness but described "nervous breakdown" in non-psychotic terms and classified it as mental illness	5
Described "non-insane" in psychotic terms	15
Used diagnostic labels with other than technical meaning	6
Did not include "non-insane" within mental illness, after having described non-psychotic syndromes as mental illness	4
Uninformed	
No conception of mental illness other than mental deficiency . . .	1
Apparently no conception of mental illness	2
Consistent	
Conception of mental illness limited to psychosis	7
Conception of mental illness included non-psychotic syndromes . .	28
Total per cent[a]	132
Number	3,531

[a]Total exceeds 100% because some respondents were inconsistent in more than one way.

TABLE 11

RELATION OF VIEWS OF "NERVOUS BREAKDOWNS"

TO VIEWS OF MENTAL ILLNESS

Rating of First Impression of Mental Illness and View of Non-Psychotic Mental Illness	Proportion of Each Group Classifying "Nervous Breakdown" as Mental Illness		
	All Respondents	Respondents Whose Descriptions of "Nervous Breakdown" Included Psychosis	Respondents Whose Descriptions of "Nervous Breakdown" were in Non-Psychotic Terms Only
First impression			
Psychosis only	44 (1758)[a]	66 (417)	41 (1181)
Includes non-psychotic	55 (1582)	66 (264)	56 (1194)
Other	30 (191)	75 (37)	36 (142)
Mental illness vs. "insanity"			
"Insanity" only	45 (359)	72 (89)	[illegible] (232)
Includes more than "insanity"	50 (2914)	66 (566)	[illegible] (2174)
Undecided, don't know	31 (258)	57 (63)	33 (171)
Rating of "non-insane" mental illness			
Includes psychosis	48 (523)	66 (118)	46 (355)
Non-psychotic only	51 (2012)	67 (366)	50 (1537)
Other	42 (379)	61 (82)	45 (222)
First impression was psychosis only and:			
Mental illness was "insanity" only	41 (287)	72 (78)	34 (178)
Mental illness included "non-insane," but described as including psychosis	45 (341)	62 (90)	43 (220)
Mental illness included "non-insane," described as non-psychotic only	46 (832)	67 (183)	44 (597)
First impression included non-psychotic and:			
Mental illness was "insanity" only	58 (59)	[b] (11)	59 (45)
Mental illness included "non-insane," but described as including psychosis	58 (126)	[b] (24)	56 (96)
Mental illness included "non-insane," described as non-psychotic only	56 (1158)	65 (200)	57 (887)

[a] The number in parentheses is the number of cases on which the percentage is based.

[b] Too few cases to report percentages.

TABLE 12

MENTAL ILLNESS CLASSIFICATION OF SIX EXAMPLES OF HUMAN BEHAVIOR

Classification	Proportion Classifying Given Person in Each Way					
	"Frank Jones" (Paranoid)	"Betty Smith" (Simple Schizophrenic)	"Bill Williams" (Alcoholic)	"George Brown" (Anxiety Neurotic)	"Bobby Grey" (Conduct Disturbance)	"Mary White" (Compulsive-Phobic)
Something wrong:						
Mental illness.	75	34	29	18	14	7
Undecided, don't know . .	8	9	8	7	8	2
Not mental illness. . . .	12	28	34	26	29	14
Nothing wrong.	5	29	29	49	49	77
Total per cent . . .	100	100	100	100	100	100
Number	3,531	3,531	3,531	3,531	3,531	3,531

TABLE 13

NUMBER AND TYPE OF EXAMPLES OF HUMAN BEHAVIOR CLASSIFIED AS MENTALLY-ILL

Number and Type	Proportion of All Respondents	
None is mentally-ill.		17
One is mentally-ill		34
Paranoid only	28	
Alcoholic only	3	
Simple schizophrenic only	2	
All other	1	
Two are mentally-ill.		24
Both psychotics	10	
Paranoid and alcoholic	7	
Paranoid and anxiety neurotic . . .	3	
Paranoid and child	2	
All other	2	
Three are mentally-ill		13
Both psychotics and alcoholic . . .	4	
Both psychotics and anxiety neurotic	3	
Both psychotics and child	2	
Paranoid, alcoholic and child . . .	1	
Paranoid, alcoholic and anxiety neurotic	1	
All other	2	
Four are mentally-ill		7
Both psychotics, alcoholic, anxiety neurotic	3	
Both psychotics, alcoholic, child .	2	
All other	2	
Five are mentally-ill		3
All but compulsive-phobic	2	
All but child	1	
All other	*	
All are mentally-ill		2
Total per cent		100
Number		3,531

*Less than 0.5%.

TABLE 14

RELATIONSHIP OF GENERAL IMPRESSION OF MENTAL ILLNESS TO PERCEPTION OF MENTAL ILLNESS IN SIX EXAMPLES OF HUMAN BEHAVIOR

Person or Type	Proportion Classifying Each Person or Type as Mentally-Ill among Those with Indicated "Total" Impression of Mental Illness					
	Consistent Non-Psychotic Usage		Inconsistent Non-Psychotic Usage	Inconsistent Psychotic Usage	Consistent Psychotic Usage	No Impression
	Non-Psychotic Included in First Impression	Non-Psychotic Not Included in First Impression				
"Frank Jones" (Paranoid). .	86	82	73	70	67	42
"Betty Smith" (Simple Schizophrenic).	45	40	30	31	27	14
"Bill Williams" (Alcoholic)	43	37	25	22	16	8
"George Brown" (Anxiety Neurotic)	30	24	15	13	7	6
"Bobby Grey" (Conduct Disturbance)	21	16	12	12	9	8
"Mary White" (Compulsive Phobic)	11	8	5	8	2	1
At least one of above . . .	91	90	82	77	75	52
Four-question summary:						
Personality disordered (and all others below) included	8	4	3	3	-	-
Neurosis (and all others below) included.	12	11	7	6	5	2
Limited to psychosis, generally	21	21	16	17	19	6
Limited to violent psychosis	34	36	42	38	40	33
No apparent recognition .	11	14	22	26	30	51
Usage not consistently classifiable.	14	14	10	10	6	8
Total per cent. . .	100	100	100	100	100	100
Number	572	426	1,644	548	239	102

TABLE 15

SEVERITY AND TYPE OF MENTAL ILLNESS PERCEIVED IN SIX EXAMPLES OF HUMAN BEHAVIOR

Severity or Type	Proportion Classifying Mental Illness of Given Person as Each Degree of Severity or Type among Those Who Regarded Person as Mentally-Ill					
	"Frank Jones" (Paranoid)	"Betty Smith" (Simple Schizophrenic)	"Bill Williams" (Alcoholic)	"George Brown" (Anxiety Neurotic)	"Bobby Grey" (Conduct Disturbance)	"Mary White" (Compulsive-Phobic)
SEVERITY						
Serious	71	47	73	34	62	19
Not serious	20	43	19	53	28	74
Undecided, don't know	9	10	8	13	10	7
Total per cent	100	100	100	100	100	100
DIAGNOSTIC TYPE						
Schizophrenia	3	2	*	*	*	-
Psychosis, other or unspecified	20	3	3	2	1	2
Incipient or borderline psychosis	6	2	*	1	*	*
Neurosis, emotional disorder, personality disturbance	1	2	1	3	1	5
Nerves, nervousness, nervous disorder	4	2	1	19	*	12
Non-psychotic mental illness, other or unspecified	5	8	6	9	3	9
Mental illness, not further specified	61	80	89	64	96	71
Incipient or borderline mental illness, not further specified	3	1	-	2	1	1
Total per cent[a]	103	100	100	100	102	100
Number	2,664	1,194	1,007	640	494	242

*Less than 0.5%.

[a]Totals exceed 100% because a few respondents were undecided between alternative diagnoses.

TABLE 16

CATEGORIZATION OF SIX EXAMPLES OF HUMAN BEHAVIOR

Category	Proportion Categorizing Given Person in Each Way						
	"Frank Jones" (Paranoid)	"Betty Smith" (Simple Schizophrenic)	"Bill Williams" (Alcoholic)	"George Brown" (Anxiety Neurotic)	"Bobby Grey" (Conduct Disturbance)	"Mary White" (Compulsive-(Phobic)	Any One of Preceding
ALL RESPONDENTS							
Mental illness	75	34	29	18	14	7	83
Emotional illness, disorder	*	*	*	*	*	*	1
Nervous illness, disorder	2	1	*	6	*	2	10
Physical illness, disorder	1	2	4	4	*	*	10
Other illness	*	*	5	*	*	-	6
Temperament, conditioning, personality	14	59	23	56	36	88	96
Bad will, defective character	4	1	36	6	18	1	49
Supernatural influence, witchcraft, possession	*	*	*	*	*	-	*
Reasonable response to current circumstances	2	1	4	11	22	1	35
Disapproved response to current circumstances	*	*	*	*	7	-	8
Normal, transient stage of development	-	*	*	*	4	-	4
No classification	2	2	2	3	2	3	*
Total per cent[a]	100	100	103	104	103	102	302
Number	3,531	3,531	3,531	3,531	3,531	3,531	3,531

*Less than 0.5%.

[a]Totals exceed 100% because respondents sometimes offered alternate categories.

TABLE 16--Continued

Category	Proportion Categorizing Given Person in Each Way						
	"Frank Jones" (Paranoid)	"Betty Smith" (Simple Schizophrenic)	"Bill Williams" (Alcoholic)	"George Brown" (Anxiety Neurotic)	"Bobby Grey" (Conduct Disturbance)	"Mary White" (Compulsive-Phobic)	Any One of Preceding
RESPONDENTS MAKING CATEGORIZATION OTHER THAN MENTAL ILLNESS							
Emotional illness, disorder	1	*	*	*	*	*	1
Nervous illness, disorder	8	1	*	8	*	2	10
Physical illness, disorder	4	3	5	5	*	*	10
Other illness	*	*	7	*	*	-	6
Temperament, conditioning, personality	61	94	32	70	43	98	98
Bad will, defective character	20	1	51	7	21	1	50
Supernatural influence, witchcraft, possession	*	*	*	*	*	-	*
Reasonable response to current circumstances	10	1	5	14	26	1	36
Disapproved response to current circumstances	*	*	*	*	9	-	8
Normal, transient stage of development	-	*	*	*	4	-	4
Total per cent[a]	104	100	100	104	103	102	223
Number	806	2,228	2,468	2,763	2,958	3,176	3,457

TABLE 17

CATEGORIZATION OF SIX EXAMPLES OF HUMAN BEHAVIOR IN RELATION TO JUDGMENT OF PROBLEMATICAL CHARACTER OF THE BEHAVIOR

Category	Proportion Categorizing Given Person in Each Way											
	"Frank Jones" (Paranoid)		"Betty Smith" (Simple Schizophrenic)		"Bill Williams" (Alcoholic)		"George Brown" (Anxiety Neurotic)		"Bobby Grey" (Conduct Disturbance)		"Mary White" (Compulsive-Phobic)	
	Something Wrong But Not Mental Illness[a]	Nothing Wrong	Something Wrong But Not Mental Illness[a]	Nothing Wrong	Something Wrong But Not Mental Illness[a]	Nothing Wrong	Something Wrong But Not Mental Illness[a]	Nothing Wrong	Something Wrong But Not Mental Illness[a]	Nothing Wrong	Something Wrong But Not Mental Illness[a]	Nothing Wrong
ALL RESPONDENTS												
Emotional illness, disorder	*	2	1	-	*	-	*	*	1	-	*	*
Nervous illness, disorder	9	4	1	*	1	-	12	4	-	*	5	1
Physical illness, disorder	4	2	4	1	8	1	7	3	1	*	*	*
Other illness	*	1	*	-	10	3	*	-	1	*	-	-
Temperament, conditioning, personality	56	60	87	95	30	35	61	73	43	41	88	96
Bad will, defective character	17	23	1	1	45	56	7	7	23	19	1	1
Supernatural influence, witchcraft, possession	1	-	*	*	*	*	*	*	*	*	-	-
Reasonable response to current circumstances	9	9	1	1	5	6	10	16	23	28	1	1
Disapproved response to current circumstances	*	1	*	-	*	*	*	*	7	9	-	-
Normal, transient stage of development	-	-	*	*	*	-	-	*	2	6	-	-
No classification	9	1	6	2	3	2	6	3	4	1	5	3
Total per cent[b]	105	103	101	100	102	103	103	106	105	104	100	102
Number	684	183	1,357	980	1,536	988	1,222	1,669	1,364	1,673	656	2,633

*Less than 0.5%.

[a]This category includes both people who said it was not mental illness and people who were undecided about whether or not it was mental illness.

[b]Totals exceed 100% because a few persons were undecided between alternate categories.

TABLE 18

STRUCTURE OF DISCUSSIONS OF SIX EXAMPLES OF HUMAN BEHAVIOR

Causal Reasoning	Proportion Whose Answer Included Given Descriptive Elements and Each Type of Causal Reasoning			
	Specific Psychological Trends	Spontaneous Categorization as Mental Illness Only	No Psychological Description	Total
"Frank Jones" (Paranoid)				
Not ascertained	10	1	-	11
Respondent did not know	5	3	3	11
"Personality" reasons only	7	-	-	7
Other causes	58	7	6	71
Total per cent	80	11	9	100
Number	2,806	387	338	3,531
"Betty Smith" (Simple Schizophrenic)				
Not ascertained	8	*	-	8
Respondent did not know	6	*	4	10
"Personality" reasons only	4	-	-	4
Other causes	67	1	10	78
Total per cent	85	1	14	100
Number	2,989	53	489	3,531
"Bill Williams" (Alcoholic)				
Not ascertained	26	*	-	26
Respondent did not know	6	*	2	8
"Personality" reasons only	5	-	-	5
Other causes	57	*	4	61
Total per cent	94	*	6	100
Number	3,327	13	191	3,531
"George Brown" (Anxiety Neurotic)				
Not ascertained	21	*	-	21
Respondent did not know	7	*	3	10
"Personality" reasons only	9	-	-	9
Other causes	54	*	6	60
Total per cent	91	*	9	100
Number	3,203	17	311	3,531
"Bobby Grey" (Conduct Disturbance)				
Not ascertained	9	*	-	9
Respondent did not know	2	*	3	5
"Personality" reasons only	3	-	-	3
Other causes	51	1	31	83
Total per cent	65	1	34	100
Number	2,284	25	1,222	3,531
"Mary White" (Compulsive-Phobic)				
Not ascertained	28	*	-	28
Respondent did not know	6	*	3	9
"Personality" reasons only	4	-	-	4
Other causes	57	*	2	59
Total per cent	95	*	5	100
Number	3,343	4	184	3,531

*Less than 0.5%.

TABLE 19

DESCRIPTION OF PSYCHOLOGICAL TRENDS IN SIX EXAMPLES OF HUMAN BEHAVIOR

Psychological Trend	Proportion Mentioning Each Psychological Trend for Given Person					
	"Frank Jones" (Paranoid)	"Betty Smith" (Simple Schizophrenic)	"Bill Williams" (Alcoholic)	"George Brown" (Anxiety Neurotic)	"Bobby Grey" (Conduct Disturbance)	"Mary White" (Compulsive-Phobic)
EMOTIONAL TONE						
Tense, jumpy, restless, unable to relax	4	1	1	20	*	3
Irritable, excitable, sensitive, easily upset	2	1	*	16	*	*
Unhappy, depressed	1	2	2	3	1	*
Disappointed, frustrated, dissatisfied	4	1	6	8	1	*
Worried, fearful, anxious	8	4	6	43	*	10
Emotionally disturbed, conflictful	1	1	1	1	*	*
Hostile, aggressive, difficult	12	*	2	7	2	*
Resentful, retaliatory	5	1	1	2	6	*
Shy, bashful, timid	*	21	*	*	*	*
Withdrawn, introverted, asocial	1	29	-	*	*	*
Secretive, self-concealing, compensatory	3	4	*	3	1	*
Apathetic, indifferent, inert	*	5	*	-	*	-
Defeated, surrendering, hopeless	*	1	1	1	-	*
Inhibited, repressed, emotionally inaccessible	*	*	*	*	*	*
SELF-IMAGE, CHARACTER TRAITS						
Egocentric, self-centered, demanding	3	3	3	6	4	*
Attention-seeking, self-individuating, impressing others	*	*	1	1	13	*
Boastful, self-important, self-aggrandizing	1	*	1	1	1	*
Self-righteous, self-justifying, obstinate	1	*	*	2	2	*
Insecure, lacking self-confidence, self-conscious	15	25	4	12	2	10
Self-accusatory, self-blaming, guilt feelings	7	1	2	5	*	*
Martyred, self-pitying, feelings of rejection	3	3	1	1	2	*
Weak, self-indulgent, lacking self-control	4	1	37	6	1	1
Immature, dependent, lacking self-reliance	*	2	5	1	*	1
Lazy, ne'er-do-well, irresponsible	*	1	8	*	*	*
Lacking pride, self-respect	*	*	1	-	*	*
Independent, ambitious, reasonably assertive	*	-	*	1	1	*

TABLE 19--Continued

Psychological Trend	Proportion Mentioning Each Psychological Trend for Given Person					
	"Frank Jones" (Paranoid)	"Betty Smith" (Simple Schizophrenic)	"Bill Williams" (Alcoholic)	"George Brown" (Anxiety Neurotic)	"Bobby Grey" (Conduct Disturbance)	"Mary White" (Compulsive-Phobic)
PERCEPTION OF REALITY						
Suspicious, distrustful	42	2	*	2	*	1
Inability to accept, face, adjust to reality	1	2	8	2	*	*
Lack of perspective, inadequate judgment	4	1	6	6	3	*
Unrealistic or improper goals, values	1	*	1	4	1	*
Phantasizing, day dreaming	*	3	*	-	*	*
Overimaginative, other or unspecified	7	*	*	1	1	1
INTELLECTUAL ORIENTATION						
Lacking intelligence or ability	1	3	1	1	1	*
Distracted, absentminded, forgetful	*	*	*	*	-	22
Brooding, preoccupied	9	2	1	9	*	5
Obsessive, compulsive, driven by uncontrollable impulse	1	*	14	*	2	1
Cautious, careful, conscientious	*	*	-	3	-	38
Careless, inattentive	*	*	*	-	-	5
Overactive, hurried	*	*	*	3	-	5
Idle, lacking useful occupation	1	*	*	*	2	*
Lacking diversity, balance in living	*	*	*	2	*	*
Conscious choice, preference, willed action	*	3	12	1	2	1
Other general trends	a	a	a	a	19	2
Specific, discrete fears, motives	a	16	a	a	22	61
Vague, unspecified psychological trend	2	2	15	2	5	3
No mention of any of these psychological trends	20	15	6	9	35	5
Total per cent[b]	163	154	146	185	129	175
Number	3,531	3,531	3,531	3,531	3,531	3,531

*Less than 0.5%.

[a]This category was not separately coded for this item.

[b]Totals exceed 100% because many respondents mentioned more than one descriptive category.

TABLE 20

USE OF SELECTED TERMINOLOGY IN INTERPRETING HUMAN BEHAVIOR

Term	Proportion Using Each Term in Discussing Given Person						
	"Frank Jones" (Paranoid)	"Betty Smith" (Simple Schizophrenic)	"Bill Williams" (Alcoholic)	"George Brown" (Anxiety Neurotic)	"Bobby Grey" (Conduct Disturbance)	"Mary White" (Compulsive - Phobic)	Any of Preceding
Inferiority (or "inferior") complex	9	12	1	2	*	*	21
Persecution complex	4	*	-	*	-	-	4
Guilt complex	1	*	*	*	-	*	1
Fear complex	*	*	-	*	*	1	1
Other specific complexes	*	*	*	*	*	*	1
Complex, unspecified	2	2	*	1	*	1	6
Claustrophobia, claustrophobic	-	-	-	-	-	2	2
Other compound phobia terms	-	-	-	-	-	*	*
Phobia, not compounded	1	*	*	*	*	5	6
Alcoholism, alcoholic	*	-	23	*	-	-	23
Dipsomania, dipsomaniac	-	-	*	-	-	-	*
Kleptomania, kleptomaniac	*	-	-	-	3	*	3
Other compound mania terms	-	*	-	*	*	*	*
Mania, not compounded	*	-	-	*	*	*	1
Habit	1	1	23	1	5	7	32
Superstition, superstitious	1	*	-	*	-	3	3
Fixation, fixed ideas	*	*	-	*	-	*	*
Obsession, obsessive	1	*	*	*	*	1	2
Compulsion, compulsive	*	*	*	*	*	*	1
Delusion	1	*	*	*	-	*	1
Hallucination	1	-	*	*	-	*	1
Nervousness, nervous	6	2	1	15	*	8	26
Neurosis, neurotic	1	1	*	1	*	1	3
Schizophrenia, schizophrenic	2	*	*	*	*	-	2
Psychosis, psychotic	*	*	*	*	-	*	1
Mental illness volunteered in terms other than than neurosis, psychosis, schizophrenia	35	5	3	3	1	1	40

*Less than 0.05%.

TABLE 20--Continued

Term	Proportion Using Each Term in Discussing Given Person						
	"Frank Jones" (Paranoid)	"Betty Smith" (Simple Schizophrenic)	"Bill Williams" (Alcoholic)	"George Brown" (Anxiety Neurotic)	"Bobby Grey" (Conduct Disturbance)	"Mary White" (Compulsive-Phobic)	Any of of Preceding
Introversion, introverted, introvert . . .	*	3	-	*	*	*	4
Other "technical" terms of personality analysis	1	1	1	*	*	1	3
Specific types and type words, not elsewhere classified: worrier, weakling, criminal type, etc.	1	2	12	11	2	3	27
Quirk	*	*	*	*	*	2	3
Idiosyncracy	-	-	-	*	-	*	*
Other terms implying individual deviation: eccentricity, peculiarity, notion, odd type, etc.	1	1	1	1	1	4	7
Other terms referring generally to personality or elements of personality: trait, characteristic, disposition, makeup, etc. . .	4	5	3	9	4	3	22
None of these terms used	39	72	47	61	84	64	7
Total per cent[a]	112	107	115	105	100	107	254
Number	3,531	3,531	3,531	3,531	3,531	3,531	3,531

[a]Totals exceed 100% because some respondents used more than one kind of terminology.

TABLE 21

DESCRIPTION OF PSYCHOLOGICAL TRENDS IN SIX EXAMPLES OF HUMAN BEHAVIOR IN RELATION TO JUDGMENT OF PROBLEMATICAL CHARACTER OF THE BEHAVIOR

Person and Psychological Trend	Proportion Mentioning Each Psychological Trend among Those Classifying Behavior in Indicated Way			
	Mental Illness	Something Wrong but Not Mental Illness[a]	Nothing Wrong	Total
"FRANK JONES" (PARANOID)				
ALL RESPONDENTS				
Suspicious, distrustful	42	38	36	41
Insecure, lacking self-confidence	14	15	21	15
Hostile, aggressive, difficult	10	18	23	12
Brooding, preoccupied	9	8	2	9
Worried, fearful, anxious	8	9	12	8
Self-accusatory, self-blaming, guilt-feelings	7	8	9	7
Over-imaginative	6	6	9	7
Resentful, retaliatory, rebellious	5	6	8	5
Other trends in combination with above[b]	21	26	23	22
Other trends only[b]	8	10	8	9
Vague unspecified psychological trends only	1	2	3	2
No mention of psychological trends	22	16	9	20
Total per cent[c]	153	162	163	157
Number	2,664	684	183	3,531
RESPONDENTS WHO USED PSYCHOLOGICAL DESCRIPTION				
Suspicious, distrustful	56	47	41	53
Insecure, lacking self-confidence	18	19	24	19
Hostile, aggressive, difficult	13	22	27	16
Brooding, preoccupied	12	9	2	11
Worried, fearful, anxious	10	11	14	10
Self-accusatory, self-blaming, guilt-feelings	9	10	10	9
Over-imaginative	8	8	10	8
Resentful, retaliatory, rebellious	6	8	9	7
Other trends in combination with above	28	32	27	28
Other trends only	11	12	9	11
Total per cent[c]	171	178	173	172
Number	2,012	559	161	2,732

[a]Includes those who said it was not mental illness and those who weren't sure whether or not it was mental illness.

[b]All categories included here had total frequencies of 4% or less.

[c]Totals exceed 100% because many respondents mentioned more than one category.

TABLE 21--Continued

Person and Psychological Trend	Proportion Mentioning Each Psychological Trend among Those Classifying Behavior in Indicated Way			
	Mental Illness	Something Wrong but Not Mental Illness[a]	Nothing Wrong	Total
"BETTY SMITH" (SIMPLE SCHIZOPHRENIC)				
ALL RESPONDENTS				
Withdrawn, introverted, asocial	37	23	29	29
Insecure, lacking self-confidence, self-conscious	26	29	19	25
Shy, bashful, timid	10	25	32	21
Fear, dislike of people	12	9	8	10
Apathetic, indifferent, inert	6	4	3	5
Worried, fearful, anxious	4	4	3	4
Fear, dislike of men	4	4	4	4
Secretive, self-concealing	4	4	3	4
Other trends in combination with above[b]	22	19	13	18
Other trends only[b]	11	9	8	9
Vague, unspecified psychological trend only	2	3	2	2
No mention of psychological trends	16	16	14	15
Total per cent[c]	154	149	138	146
Number	1,194	1,357	980	3,531
RESPONDENTS WHO USED PSYCHOLOGICAL DESCRIPTION				
Withdrawn, introverted, asocial	45	28	34	35
Insecure, lacking self-confidence, self-conscious	31	35	22	30
Shy, bashful, timid	12	30	38	26
Fear, dislike of people	15	11	10	12
Apathetic, indifferent, inert	7	5	4	6
Worried, fearful, anxious	7	5	4	5
Fear, dislike of men	6	5	4	5
Secretive, self-concealing	5	5	4	5
Other trends in combination with above	27	23	15	22
Other trends only	13	11	9	11
Total per cent[c]	168	158	144	157
Number	981	1,100	820	2,901

TABLE 21--Continued

Person and Psychological Trend	Proportion Mentioning Each Psychological Trend among Those Classifying Behavior in Indicated Way			
	Mental Illness	Something Wrong but Not Mental Illness[a]	Nothing Wrong	Total
"BILL WILLIAMS" (ALCOHOLIC)				
ALL RESPONDENTS				
Weak, self-indulgent, lacking self-control	39	37	35	37
Obsessive, compulsive, driven by uncontrollable impulse	13	17	10	14
Conscious choice, preference, willed action	6	12	20	12
Lazy, ne'er-do-well, irresponsible	5	8	12	8
Unable to accept, face, adjust to reality	16	6	4	8
Lacking perspective, judgment inadequate	8	5	4	6
Dissapointed, frustrated, dissatisfied	8	5	4	6
Worried, fearful, anxious	6	5	5	6
Immature, dependent, lacking self-reliance	6	5	4	5
Other trends in combination with above[b]	19	15	11	15
Other trends only[b]	7	7	6	7
Vague, unspecified psychological trend only	12	15	17	15
No mention of psychological trends	6	6	5	6
Total per cent[c]	151	143	137	145
Number	1,007	1,536	988	3,531
RESPONDENTS WHO USED PSYCHOLOGICAL DESCRIPTION				
Weak, self-indulgent, lacking self-control	47	46	45	46
Obsessive, compulsive, driven by uncontrollable impulse	16	21	12	17
Conscious choice, preference, willed action	11	19	25	15
Lazy, ne'er-do-well, irresponsible	6	11	15	11
Unable to accept, face, adjust to reality	19	8	5	11
Lacking perspective, judgment inadequate	10	7	6	7
Disappointed, frustrated, dissatisfied	10	7	5	7
Worried, fearful, anxious	8	5	6	6
Immature, dependent, lacking self-reliance	8	6	5	6
Other trends in combination with above	23	19	14	19
Other trends only	9	9	8	9
Total per cent[c]	167	158	146	154
Number	828	1,211	770	2,809

TABLE 21--Continued

Person and Psychological Trend	Proportion Mentioning Each Psychological Trend among Those Classifying Behavior in Indicated Way			
	Mental Illness	Something Wrong but Not Mental Illness[a]	Nothing Wrong	Total
"GEORGE BROWN" (ANXIETY NEUROTIC) ALL RESPONDENTS				
Worried, fearful, anxious	50	38	42	43
Tense, jumpy, restless, unable to relax	23	21	19	20
Irritable, excitable, sensitive, easily upset	18	16	16	16
Insecure, lacking self-confidence	16	13	10	12
Brooding, preoccupied	14	9	8	9
Disappointed, frustrated, dissatisfied.	9	7	7	8
Hostile, aggressive, difficult	8	7	7	7
Egocentric, self-centered, demanding.	7	7	6	6
Lacking perspective, judgment inadequate	6	6	6	6
Weak, self-indulgent, lacking self-control	7	5	6	6
Self-accusatory, self-blaming, guilt feeling	6	6	4	5
Other trends in combination with above[b]	26	24	21	23
Other trends only[b]	5	5	8	6
Vague, unspecified psychological trend only	1	2	2	2
No mention of psychological trends	6	12	8	9
Total per cent[c]	202	178	170	178
Total	640	1,222	1,669	3,531
RESPONDENTS WHO USED PSYCHOLOGICAL DESCRIPTION				
Worried, fearful, anxious	54	44	47	47
Tense, jumpy, restless, unable to relax	25	25	21	23
Irritable, excitable, sensitive, easily upset	19	18	18	18
Insecure, lacking self-confidence	17	15	11	13
Brooding, preoccupied	15	10	9	11
Disappointed, frustrated, dissatisfied.	10	8	8	9
Hostile, aggressive, difficult	9	8	8	8
Egocentric, self-centered, demanding.	7	8	7	7
Lacking perspective, judgment inadequate	7	7	7	7
Weak, self-indulgent, lacking self-control	7	6	6	6
Self-accusatory, self-blaming, guilt feelings	6	7	4	6
Other trends in combination with above.	28	28	24	26
Other trends only	5	6	9	7
Total per cent[c]	209	190	179	188
Number	594	1,049	1,499	3,143

TABLE 21--Continued

Person and Psychological Trend	Proportion Mentioning Each Psychological Trend among Those Classifying Behavior in Indicated Way			
	Mental Illness	Something Wrong but Not Mental Illness[a]	Nothing Wrong	Total
"BOBBY GREY" (CONDUCT DISTURBANCE)				
ALL RESPONDENTS				
Attention-seeking, self-individuating, impressing others	14	14	13	13
Craving, desiring things	12	9	10	10
Resentful, retaliatory, rebellious	8	7	5	6
Fearful of punishment	5	6	4	5
Egocentric, self-centered, demanding	3	4	5	4
Craving excitement, loving adventure	3	4	4	4
Delinquent, anti-social, evil	13	6	3	6
Bad, naughty, "ornery"	3	9	7	7
Full of life, lively, mischievous	*	2	4	3
Experimenting, reality-testing	*	3	4	3
Other trends in combination with above[b]	17	15	13	14
Other trends only[b]	21	13	11	13
Vague, unspecified trend only	4	6	5	5
No mention of psychological trends	26	33	40	35
Total per cent[c]	129	131	128	128
Number	494	1,364	1,673	3,531
RESPONDENTS WHO USED PSYCHOLOGICAL DESCRIPTION				
Attention-seeking, self-individuating, impressing others	19	22	24	23
Craving, desiring things	17	15	17	16
Resentful, retaliatory, rebellious	12	11	9	10
Fearful of punishment	7	10	8	9
Egocentric, self-centered, demanding	4	6	8	7
Craving excitement, loving adventure	5	7	6	6
Delinquent, anti-social, evil	19	10	6	10
Bad, naughty, "ornery"	5	14	13	12
Full of life, lively, mischievous	1	3	7	4
Experimenting, reality-testing	1	5	7	5
Other trends in combination with above	25	24	24	24
Other trends only	30	22	19	22
Total per cent[c]	145	149	148	148
Number	345	833	920	2,098

TABLE 21--Continued

Person and Psychological Trend	Proportion Mentioning Each Psychological Trend among Those Classifying Behavior in Indicated Way			
	Mental Illness	Something Wrong but Not Mental Illness[a]	Nothing Wrong	Total
"MARY WHITE" (COMPULSIVE-PHOBIC)				
ALL RESPONDENTS				
Cautious, careful, conscientious	13	25	44	38
Distracted, absentminded, forgetful	29	23	20	22
Worried, fearful, anxious	21	16	9	10
Insecure, lacking self-confidence	19	13	8	10
Careless, inattentive	3	8	4	5
Overactive, hurried	3	7	5	5
Brooding, preoccupied	4	4	5	5
Fear of elevators	28	37	46	43
Fear of heights	8	6	6	6
Fear of fire	5	5	5	5
Fear of death	6	4	5	5
Fear of closed spaces	8	4	3	4
Fear of falling	3	2	2	2
Other and unspecified discrete fears or phobias	14	15	10	11
Other trends in combination with above[b]	16	14	8	10
Other trends only[b]	4	4	2	2
Vague, unspecified psychological trends only	4	3	3	3
No mention of psychological trends	6	7	5	5
Total per cent[c]	194	197	190	191
Number	242	656	2,633	3,531
RESPONDENTS WHO USED PSYCHOLOGICAL DESCRIPTION				
Cautious, careful, conscientious	14	27	48	42
Distracted, absentminded, forgetful	33	26	22	24
Worried, fearful, anxious	23	17	9	12
Insecure, lacking self-confidence	21	14	9	11
Careless, inattentive	5	9	5	6
Overactive, hurried	3	7	6	6
Brooding, preoccupied	4	4	5	5
Fear of elevators	31	41	50	47
Fear of heights	9	7	7	7
Fear of fire	6	6	5	5
Fear of death	6	4	5	5
Fear of closed spaces	9	5	4	4
Fear of falling	3	3	3	3
Other and unspecified discrete fears or phobias	16	16	11	12
Other trends in combination with above	18	15	9	10
Other trends only	5	4	2	3
Total per cent[c]	206	205	200	202
Number	218	589	2,415	3,222

TABLE 22

CAUSAL EXPLANATIONS OF SIX EXAMPLES OF HUMAN BEHAVIOR

Cause	Proportion Mentioning Each Cause for Given Person					
	"Frank Jones" (Paranoid)	"Betty Smith" (Simple Schizophrenic)	"Bill Williams" (Alcoholic)	"George Brown" (Anxiety Neurotic)	"Bobby Grey" (Conduct Disturbance)	"Mary White" (Compulsive-Phobic)
SUMMARY						
Physical factors affecting brain, nervous system	22	7	16	4	2	1
General physical causes	11	4	2	15	1	1
Innate personality, will, choice	14	8	10	15	8	6
External environment, circumstances	29	17	39	37	8	2
Direct, equivalent conditioning	27	49	19	2	55	52
Psychodynamic relationships, other than conditioning	11	24	11	11	36	2
Causes too vague to classify	2	1	1	2	*	3
Don't know causes	11	10	8	10	5	9
Answered in descriptive terms only	11	8	26	21	9	28
Total per cent[a]	138	128	132	117	124	104
Number	3,531	3,531	3,531	3,531	3,531	3,531
DETAIL						
PHYSICAL FACTORS AFFECTING BRAIN, NERVOUS SYSTEM						
Hereditary or congenital mental illness or tendency toward mental illness	6	3	*	*	1	*
Physical affects of alcohol, alcoholism	9	*	13	1	-	*
Physical effects of "drug" addiction	1	*	-	1	-	*
Venereal disease	1	*	*	*	-	-
Physical effects of masturbation	-	*	*	*	-	-
Physical effects of other sex practices	*	1	-	*	-	-
Accidents, injuries to brain, nervous system	4	1	*	*	*	*
Physical effects of accidents or injuries, other or unspecified	2	*	*	*	*	*
Ill-defined organic malfunctioning of brain or nervous system	3	1	2	1	*	1
Diseases that clearly affect brain or nervous system, not elsewhere classified	1	*	*	*	*	*
Senility, diseases of old age	*	-	-	-	-	-
Menopause	*	-	-	*	-	-
Other glandular disorders	*	2	-	*	1	*
Toxic and convulsive disorders	*	*	*	*	*	*

*Less than 0.5%.

[a]Totals exceed 100% because some respondents mentioned more than one type of cause.

TABLE 22--Continued

Cause	Proportion Mentioning Each Cause for Given Person					
	"Frank Jones" (Paranoid)	"Betty Smith" (Simple Schizophrenic)	"Bill Williams" (Alcoholic)	"George Brown" (Anxiety Neurotic)	"Bobby Grey" (Conduct Disturbance)	"Mary White" (Compulsive-Phobic)
OTHER PHYSICAL CAUSES						
Overwork	5	*	*	7	-	*
Bad physical health practices, other or unspecified	1	*	*	1	*	*
General physical effects of disease, illness	3	2	1	4	*	*
General effects on susceptibility from poor physical health	2	2	*	3	*	*
Specific diseases, not elsewhere classified	1	*	*	3	*	*
INNATE PERSONALITY, WILL, CHOICE						
Hereditary, constitutional or congenital determination of specific behavioral or personality patterns	2	4	6	5	6	2
Prenatal influences, "marking" of child	*	*	*	*	*	1
Fate, predestination, possession, supernatural influences	*	*	*	*	*	*
Vague, ill-defined but inherent or innate "nature"	*	1	*	2	1	*
Causal significance attributed to psychological tendencies:						
"Entities" like complexes, phobias, habits, etc.	*	*	-	*	*	*
"Discrete traits" like fear of elevator, dislike of father, etc.	-	-	-	-	*	*
Disordered self-image or character traits	1	*	*	*	*	*
Disordered emotional tone	1	*	*	*	*	*
Distortion of reality	1	*	-	*	*	*
Person's own objective misdoings	8	*	1	7	*	*
Intellect, thought, cognition, intent	1	*	*	*	*	*
EXTERNAL ENVIRONMENT, CIRCUMSTANCES						
"Reasonable" response to own physical qualities, appearance, practices	3	5	2	2	*	*
Present economic deprivations or difficulties	8	*	5	7	1	*
Past economic deprivations or difficulties	1	*	1	4	*	*
Present job conditions, problems, difficulties	3	-	3	8	-	*
Past job conditions, problems, difficulties	1	-	*	1	-	*
Objectively handicapping, competitively disadvantaging circumstances outside individual's control	1	3	*	1	*	*
Rapid pace, confusion, complexity, insecurity of modern life	*	-	*	2	*	*
Cumulative pressures of every-day problems of living	1	*	1	1	-	*
Failure, frustration, disappointment, vague	4	1	4	3	*	*
Other or unspecified external, objective difficulties	5	1	1	1	1	*

TABLE 22—Continued

Cause	Proportion Mentioning Each Cause for Given Person					
	"Frank Jones" (Paranoid)	"Betty Smith" (Simple Schizophrenic)	"Bill Williams" (Alcoholic)	"George Brown" (Anxiety Neurotic)	"Bobby Grey" (Conduct Disturbance)	"Mary White" (Compulsive - Phobic)
DIRECT, EQUIVALENT CONDITIONING						
Influence of mass media	*	*	*	*	4	5
Influence of experiences of others	*	*	*	1	*	8
Others were precept, example; influenced person to act as they do	2	2	20	2	27	7
Other related experience	b	b	b	b	b	39
INTERPERSONAL RELATIONSHIPS[c]						
ACTS:						
Others failed to:						
Provide sufficient spending money	-	-	-	*	12	-
Provide other material things needed	*	*	-	*	6	-
Teach sociability, social conduct	*	2	-	*	*	-
Teach reasonable attitudes toward sex	-	5	-	-	*	-
Teach values, moral standards; inculcate, develop character, other or unspecified	1	1	2	1	11	*
Encourage contacts with people	*	4	*	*	*	-
Provide constructive activities	-	*	1	*	1	-
Exercise discipline, control, supervision, other or unspecified	*	*	*	1	20	*
Foster self-confidence	*	1	-	*	*	*
Give love, satisfy emotional needs	3	3	1	1	8	*
Other specific acts of omission	*	*	*	-	*	-
Neglect or inattention, vague and unclassifiable	1	2	*	*	5	*

[b] Not separately coded for this item.

[c] "Interpersonal relationships" are classified as either "external environment, circumstances," "direct, equivalent conditioning" or "psychodynamic relationships," but the exact sub-categories so assigned varies with the particular case. In general, interpersonal experiences in adult life are assigned either to "external environment, circumstances" or to "direct, equivalent conditioning," while interpersonal relationships that are not clearly adult are assigned either to "conditioning" or to "psychodynamics." The exact sub-categories so classified are discussed in text with reference to each case.

TABLE 22--Continued

Cause	Proportion Mentioning Each Cause for Given Person					
	"Frank Jones" (Paranoid)	"Betty Smith" (Simple Schizophrenic)	"Bill Williams" (Alcoholic)	"George Brown" (Anxiety Neurotic)	"Bobby Grey" (Conduct Disturbance)	"Mary White" (Compulsive-Phobic)
ACTS: Continued						
Others were overindulgent, overprotective, overattentive	1	5	3	4	7	1
Others slighted, rejected, ostracized because of person's characteristics	*	1	*	-	*	-
Others slighted, rejected, ostracized, other or unspecified	1	4	*	*	*	-
Others ridiculed, belittled, humiliated, actively undermined person's self-confidence, because of person's characteristics	1	2	*	*	*	*
Others ridiculed, belittled, humiliated, actively undermined person's self-confidence, other or unspecified	3	9	*	1	1	*
Others barred, restricted person from contacts with people	*	16	-	*	*	-
Others made excessive demands on, set unreasonable standards for person	*	1	*	1	1	*
Others improperly resolved normal (Freudian) sexual psychodynamics	-	*	*	-	-	-
Others have been too strict, dominating or repressive, other or unspecified	2	11	1	1	9	*
Others discriminated against person, treated him invidiously	1	2	*	*	1	-
Others sexually injured person	-	2	-	-	-	-
Others objectively betrayed person's trust, confidence	11	1	1	2	-	-
Others acted unfairly, unjustly, inconsistently toward person, other and unspecified	2	*	*	*	2	-
Others frightened person, vague and unspecified	*	3	-	*	*	*
Others acted damagingly, hostilely, distrustfully toward person, other and unspecified	8	4	2	2	2	*
Others (with whom person compared himself) were or appeared to be superior, better-off	2	2	*	*	4	*

TABLE 22--Continued

Cause	Proportion Mentioning Each Cause for Given Person					
	"Frank Jones" (Paranoid)	"Betty Smith" (Simple Schizophrenic)	"Bill Williams" (Alcoholic)	"George Brown" (Anxiety Neurotic)	"Bobby Grey" (Conduct Disturbance)	"Mary White" (Compulsive-Phobic)
ACTS: Continued						
Others have contributed to an atmosphere of dissension	2	2	*	1	2	*
Relationships with others were conflictful, unpleasant, unhappy (e.g. "family troubles")	10	4	16	13	2	*
Relationships with loved ones have been involuntarily disrupted, terminated (e.g. deaths)	2	*	1	1	*	*
Relationships with others are lacking, absent (i.e. not otherwise explained social isolation)	*	4	*	*	*	-
Relationships with others, vague and unspecified	2	4	1	1	*	1
ACTORS:						
Parents	13	48	9	10	67	2
Spouse	7	-	13	7	-	-
Off-spring	1	-	1	1	-	-
Siblings	1	1	*	*	1	*
Family, generally	7	3	8	6	*	*
Parental surrogates	1	1	*	*	2	*
Romantic partners	1	6	1	2	-	1
Business associates	2	-	*	2	-	-
Other specific adults: friends, etc.	2	2	16	1	*	*
Other specific children: playmates, etc.	3	4	*	*	29	*
Actor not identified: someone, somebody, etc.	16	15	3	4	2	1

TABLE 23

CAUSAL EXPLANATIONS OF SIX EXAMPLES OF HUMAN BEHAVIOR, IN RELATION TO JUDGMENT OF THE PROBLEMATICAL CHARACTER OF THE BEHAVIOR

Cause	Proportion Mentioning Each Cause for Given Person and Classification																	
	"Frank Jones" (Paranoid)			"Betty Smith" (Simple Schizophrenic)			"Bill Williams" (Alcoholic)			"George Brown" (Anxiety Neurotic)			"Bobby Grey" (Conduct Disturbance)			"Mary White" (Compulsive-Phobic)		
	Mental Illness	Something Wrong but Not Mental Illness[a]	Nothing Wrong	Mental Illness	Something Wrong but Not Mental Illness[a]	Nothing Wrong	Mental Illness	Something Wrong but Not Mental Illness[a]	Nothing Wrong	Mental Illness	Something Wrong but Not Mental Illness[a]	Nothing Wrong	Mental Illness	Something Wrong but Not Mental Illness[a]	Nothing Wrong	Mental Illness	Something Wrong but Not Mental Illness[a]	Nothing Wrong
Physical factors affecting brain, nervous system . . .	24	17	9	12	6	1	16	18	12	9	4	3	9	2	1	7	3	*
General physical causes . .	11	10	7	5	5	2	2	2	1	12	20	13	2	1	*	5	2	1
Innate personality, will, choice	12	16	17	6	7	9	8	8	6	14	15	13	15	9	6	2	4	4
External environment, circumstances	31	26	20	20	16	14	42	39	38	39	36	37	8	9	8	6	3	2
Direct, equivalent conditioning	26	30	30	47	51	51	17	20	21	3	2	2	37	54	61	45	48	53
Psychodynamic relationships, other than conditioning . .	11	9	8	26	25	21	13	11	11	15	12	8	39	41	31	4	4	2
Causes too vague to classify	3	2	2	2	2	1	1	1	1	1	2	1	1	*	*	6	4	3
Don't know causes	11	11	6	11	10	8	7	9	7	4	12	9	7	7	3	12	13	7
Answered in descriptive terms only	11	12	22	7	9	15	28	25	32	19	16	28	10	7	12	21	25	32
Total per cent[b] . . .	140	133	121	136	131	122	134	133	129	116	119	114	128	130	122	108	106	104
Number	2,664	684	183	1,194	1,357	980	1,007	1,536	988	640	1,222	1,669	494	1,364	1,673	242	656	2,633

*Less than 0.5%.

[a]Includes those who said it was not mental illness and those who weren't sure whether or not it was mental illness.

[b]Totals exceed 100% because some respondents mentioned more than one type of cause.

TABLE 24

CAUSAL EXPLANATION OF SIX EXAMPLES OF HUMAN BEHAVIOR, IN RELATION TO CATEGORIZATION OF THE BEHAVIOR

Person and Cause of Behavior	Proportion Mentioning Each Type of Cause among Those Making Indicated Categorization of the Behavior [a]					
	Mental Illness	Nervous, Emotional or Other Illness	Physical Illness	Temperament, Conditioning, Personality	Bad Will, Defective Character	Response to Current Circumstances
"FRANK JONES" (PARANOID)						
Physical factors affecting brain, nervous system	24	19	b	10	20	25
General physical causes	11	28		4	3	20
Innate personality, will, choice	12	16		15	33	3
External environment, circumstances	31	31		22	13	64
Direct, equivalent conditioning	26	25		40	13	23
Psychodynamic relationships, other than conditioning	11	1		14	5	-
Causes too vague to classify	3	3		3	1	-
Don't know causes	11	6		5	8	3
Answered in descriptive terms only	11	10		14	24	-
Total per cent[c]	140	139		127	120	138
Number	2,664	68	22	473	151	61

[a] Respondents who made alternative categorizations of the same hypothetical person are omitted.

[b] Too few cases to report percentages.

[c] Totals exceed 100% because some respondents mentioned more than one type of cause.

TABLE 24--Continued

Person and Cause of Behavior	Proportion Mentioning Each Type of Cause among Those Making Indicated Categorization of the Behavior[a]					
	Mental Illness	Nervous, Emotional or Other Illness	Physical Illness	Temperament, Conditioning, Personality	Bad Will, Defective Character	Response to Current Circumstances
"BETTY SMITH" (SIMPLE SCHIZOPHRENIC)						
Physical factors affecting brain, nervous system	12	13	66	2	b	b
General physical causes	5	10	32	3		
Innate personality, will, choice	6	3	2	9		
External environment, circumstances	20	26	9	15		
Direct, equivalent conditioning	47	35	9	54		
Psychodynamic relationships, other than conditioning	26	23	7	25		
Causes too vague to classify	2	3	2	1		
Don't know causes	11	-	2	6		
Answered in descriptive terms only	7	6	2	9		
Total per cent[c]	136	119	131	124		
Number	1,194	31	44	2,073	24	22

TABLE 24--Continued

Person and Cause of Behavior	Proportion Mentioning Each Type of Cause among Those Making Indicated Categorization of the Behavior[a]					
	Mental Illness	Nervous, Emotional or Other Illness	Physical Illness	Temperament, Conditioning, Personality	Bad Will, Defective Character	Response to Current Circumstances
"BILL WILLIAMS" (ALCOHOLIC)						
Physical factors affecting brain, nervous system	16	18	46	15	13	8
General physical causes	2	2	8	1	1	3
Innate personality, will, choice	8	7	10	10	10	-
External environment, circumstances	42	45	27	41	34	90
Direct, equivalent conditioning	17	22	20	17	24	7
Psychodynamic relationships, other than conditioning	13	8	9	9	14	-
Causes too vague to classify	1	1	2	1	1	4
Don't know causes	7	9	7	10	6	3
Answered in descriptive terms only	28	24	14	25	34	-
Total per cent[c]	134	136	143	129	137	115
Number	1,007	191	127	784	1,221	102

TABLE 24--Continued

Person and Cause of Behavior	Proportion Mentioning Each Type of Cause among Those Making Indicated Categorization of the Behavior[a]					
	Mental Illness	Nervous, Emotional or Other Illness	Physical Illness	Temperament, Conditioning, Personality	Bad Will, Defective Character	Response to Current Circumstances
"GEORGE BROWN" (ANXIETY NEUROTIC)						
Physical factors affecting brain, nervous system	9	9	16	2	2	1
General physical causes	12	40	85	9	3	22
Innate personality, will, choice	14	8	1	17	25	1
External environment, circumstances	39	34	4	32	9	87
Direct, equivalent conditioning	3	5	-	3	1	-
Psychodynamic relationships, other than conditioning	15	4	1	11	23	-
Causes too vague to classify	1	-	-	2	1	1
Don't know causes	4	8	1	8	9	2
Answered in descriptive terms only	19	18	3	28	36	-
Total per cent[c]	116	126	111	112	109	114
Number	640	211	79	1,857	179	297

TABLE 24--Continued

Person and Cause of Behavior	Proportion Mentioning Each Type of Cause among Those Making Indicated Categorization of the Behavior[a]					
	Mental Illness	Nervous, Emotional or Other Illness	Physical Illness	Temperament, Conditioning, Personality	Bad Will, Defective Character	Response to Current Circumstances
"BOBBY GREY" (CONDUCT DISTURBANCE)						
Physical factors affecting brain, nervous system	9	b	b	*	1	*
General physical causes	2			*	*	1
Innate personality, will, choice	15			7	9	1
External environment, circumstances	8			8	6	14
Direct, equivalent conditioning	37			55	56	74
Psychodynamic relationships, other than conditioning	39			41	30	41
Causes too vague to classify	1			*	-	1
Don't know causes	7			2	5	3
Answered in descriptive terms only	10			11	9	-
Total per cent[c]	128			124	116	135
Number	494	20	4	1,181	599	920

*Less than 0.5%.

TABLE 24---Continued

Person and Cause of Behavior	Proportion Mentioning Each Type of Cause among Those Making Indicated Categorization of the Behavior[a]					
	Mental Illness	Nervous, Emotional or Other Illness	Physical Illness	Temperament, Conditioning, Personality	Bad Will, Defective Character	Response to Current Circumstances
"MARY WHITE" (COMPULSIVE-PHOBIC)						
Physical factors affecting brain, nervous system	7	18	b	1	b	b
General physical causes	5	11		1		
Innate personality, will, choice	2	9		4		
External environment, circumstances	6	4		2		
Direct, equivalent conditioning	45	20		58		
Psychodynamic relationships, other than conditioning	4	2		3		
Causes too vague to classify	6	5		3		
Don't know causes	12	7		7		
Answered in descriptive terms only	21	36		30		
Total per cent[c]	108	112		109		
Number	242	55	1	3,065	21	12

TABLE 25

TIME REFERENCE OF CAUSAL EXPLANATIONS OF FIVE EXAMPLES OF HUMAN BEHAVIOR[a]

Time Period	Proportion Locating Causes of Given Person's Behavior at Each Time Period				
	"Frank Jones" (Paranoid)	"Betty Smith" (Simple Schizophrenic)	"Bill Williams" (Alcoholic)	"George Brown" (Anxiety Neurotic)	"Mary White" (Compulsive-Phobic)
Adult life only	41	15	50	44	15
Adult life or indeterminable time as alternatives	3	4	2	3	4
Adult life or childhood as alternatives	8	9	4	4	6
Childhood reinforced by adult life	1	1	*	1	*
Childhood only	14	38	6	10	14
Indeterminate time	22	24	12	17	33
No mention of causes	11	9	26	21	28
Total per cent	100	100	100	100	100
Number	3,531	3,531	3,531	3,531	3,531

*Less than 0.5%.

[a]Since "Bobby Grey" was presented as a child, the time reference of all causes of his behavior was necessarily located in his childhood and is, therefore, omitted.

TABLE 26

TIME REFERENCE OF CAUSAL EXPLANATIONS OF FIVE EXAMPLES OF HUMAN BEHAVIOR, IN RELATION TO CATEGORIZATION OF THE BEHAVIOR[a]

Person and Time Reference of Causal Explanation	Proportion Making Each Time Reference, among Those Making Indicated Categorization of the Behavior[b]					
	Mental Illness	Nervous, Emotional or Other Illness	Physical Illness	Temperament, Conditioning, Personality	Bad Will, Defective Character	Response to Current Circumstances
"FRANK JONES" (PARANOID)						
Adult life only	40	56	c	30	40	92
Adult life or indeterminate time as alternatives	3	6		3	2	-
Adult life or childhood as alternatives	9	3		8	6	-
Childhood reinforced by adult life	1	-		1	1	-
Childhood only	14	3		22	6	-
Indeterminate time	22	22		22	21	8
No mention of causes	11	10		14	24	-
Total per cent	100	100		100	100	100
Number	2,664	68	22	473	151	61
"BETTY SMITH" (SIMPLE SCHIZOPHRENIC)						
Adult life only	16	33	78	12	c	c
Adult life or indeterminate time as alternatives	6	10	2	4		
Adult life or childhood as alternatives	11	-	14	8		
Childhood reinforced by adult life	1	3	-	1		
Childhood only	36	29	2	42		
Indeterminate time	23	19	2	24		
No mention of causes	7	6	2	9		
Total per cent	100	100	100	100		
Number	1,194	31	44	2,073	24	22

[a]Since "Bobby Grey" was presented as a child, the time reference of all causes of his behavior was necessarily located in his childhood and is, therefore, omitted.

[b]Respondents who made alternative categorizations of the same hypothetical person are omitted.

[c]Too few cases to report percentages.

TABLE 26--Continued

Person and Time Reference of Causal Explanation	Proportion Making Each Time Reference, among Those Making Indicated Categorization of the Behavior[b]					
	Mental Illness	Nervous, Emotional or Other Illness	Physical Illness	Temperament, Conditioning, Personality	Bad Will, Defective Character	Response to Current Circumstances
"BILL WILLIAMS" (ALCOHOLIC)						
Adult life only	46	55	69	50	44	92
Adult life or indeterminate time as alternatives	3	2	-	3	1	6
Adult life or childhood as alternatives	5	3	3	3	4	-
Childhood reinforced by adult life	*	1	-	*	*	-
Childhood only	7	3	2	4	6	-
Indeterminate time	11	12	12	15	11	2
No mention of causes	28	24	14	25	34	-
Total per cent	100	100	100	100	100	100
Number	1,007	191	127	784	1,221	102
"GEORGE BROWN" (ANXIETY NEUROTIC)						
Adult life only	38	65	96	37	22	98
Adult life or indeterminate time as alternatives	4	1	-	2	1	1
Adult life or childhood as alternatives	6	1	1	4	4	-
Childhood reinforced by adult life	1	*	-	*	1	-
Childhood only	14	3	-	11	20	-
Indeterminate time	18	12	-	18	16	1
No mention of causes	19	18	3	28	36	-
Total per cent	100	100	100	100	100	100
Number	640	211	79	1,857	179	297
"MARY WHITE" (COMPULSIVE-PHOBIC)						
Adult life only	13	29	c	13	c	c
Adult life or indeterminate time as alternatives	2	2		4		
Adult life or childhood as alternatives	6	-		6		
Childhood reinforced by adult life	*	-		*		
Childhood only	26	2		14		
Indeterminate time	32	31		33		
No mention of causes	21	36		30		
Total per cent	100	100		100		
Number	242	55	1	3,065	21	22

*Less than 0.5%.

TABLE 27

Reasons for Classifying Human Behavior as Mental Illness

Reason	Proportion Giving Each Reason — Respondents Classifying Given Behavior as Mental Illness							Any One of Preceding[a]
	"Frank Jones" (Paranoid)	"Betty Smith" (Simple Schizophrenic)	"Bill Williams" (Alcoholic)	"George Brown" (Anxiety Neurotic)	"Bobby Grey" (Conduct Disturbance)	"Mary White" (Compulsive-Phobic)	"Nervous Breakdown"	
ITS CHARACTER								
Lack of sociability, withdrawal, disruption of social relations is mental illness	*	29	-	*	-	-	b	10
Apathy, indifference, lack of interests or activities is mental illness	*	7	*	-	-	-	b	3
Disordered outlook or emotional response, other or unspecified, is mental illness	28	13	4	42	7	38	5	33
Weakness, self-indulgence, failure to exercise self-control is mental illness	2	2	28	5	1	4	7	14
Physically violent behavior is mental illness	13	*	1	*	-	*	b	11
Intellectual deterioration, cognitive impairment is mental illness	4	3	4	2	7	18	5	10
Impaired functioning, inability to cope with reality is mental illness	2	6	9	4	2	2	3	7
Anti-social, criminal behavior is mental illness	*	*	1	*	22	-	b	4
Uncontrolled, irrational behavior, other or unspecified, is mental illness	10	1	24	6	19	5	9	21
Socially deviant behavior, generally, is mental illness	15	21	4	6	14	7	3	20
Personally deviant behavior, generally, is mental illness	1	*	*	*	-	*	b	1

*Less than 0.5%.

[a]This column represents the proportion of the entire sample who cited each reason in response to any of the preceding seven items, irrespective of whether or not they classified the item as mentally ill.

[b]This category was not separately coded for "nervous breakdown."

TABLE 27--Continued

Reason	Proportion Giving Each Reason							
	Respondents Classifying Given Behavior as Mental Illness							Any One of Preceding[a]
	"Frank Jones" (Paranoid)	"Betty Smith" (Simple Schizophrenic)	"Bill Williams" (Alcoholic)	"George Brown" (Anxiety Neurotic)	"Bobby Grey" (Conduct Disturbance)	"Mary White" (Compulsive-Phobic)	"Nervous Breakdown"	
ITS CAUSAL IMPLICATIONS								
Emotional or mental strain, conflict, fatigue is the cause of the behavior or symptoms	5	4	4	14	4	7	20	19
Behavior or symptoms have no "real" (physical) causes, affect only the mind, are "all in the mind" . . .	9	7	5	9	7	10	11	16
Behavior or symptoms proceed from, can only be accounted for by, mental illness (Mental illness is the cause of behavior which cannot be otherwise explained)	8	6	6	6	11	5	b	12
Physical causes or conditions have mental consequences	1	1	12	1	1	1	4	8
Brain is part of, related to, affected by, nervous system	*	*	*	*	-	1	10	6
Malfunctioning of nervous system is, causes, mental illness . . .	1	1	*	2	*	2	6	4
ITS TREATMENT IMPLICATIONS								
Indicated procedures are "psychiatric"	1	2	2	2	3	2	2	7
Recovery is difficult, impossible	*	*	*	*	1	-	1	1
Don't know reasons	1	2	2	2	2	1	3	1
Reasons too vague to classify . . .	17	11	10	13	16	8	21	7
No reason given	2	1	1	1	1	2	1	9
Total per cent[c]	120	117	117	115	118	113	111	224
Number	2,664	1,194	1,007	640	494	242	1,682	3,531

[c]Totals exceed 100% because some respondents mentioned more than one reason.

TABLE 28

REASONS FOR NOT CLASSIFYING HUMAN BEHAVIOR AS MENTAL ILLNESS

Reason	Proportion Giving Each Reason							
	Respondents Not Classifying Given Behavior as Mental Illness							Any One of Preceding[a]
	"Frank Jones" (Paranoid)	"Betty Smith" (Simple Schizophrenic)	"Bill Williams" (Alcoholic)	"George Brown" (Anxiety Neurotic)	"Bobby Grey" (Conduct Disturbance)	"Mary White" (Compulsive-Phobic)	"Nervous Breakdown"	
ITS CHARACTER								
Nothing is wrong, not further specified	16	25	27	35	23	44	b	b
Behavior is widespread, commonplace	4	5	5	16	16	24	1	43
Behavior is desirable, non-problematic (i.e. "sensible," "reasonable"	1	3	1	2	1	14	b	17
Behavior is not classifiable as psychosis	4	2	3	2	3	2	7	11
Behavior is not sufficiently deviant, other or unspecified	4	3	1	3	1	3	2	10
"Mind," thought, rationality, intellectual or cognitive processes are not affected	1	4	9	2	6	2	6	20
Functioning is not (seriously) impaired	5	1	1	6	*	4	b	10
Behavior is not (completely) uncontrolled, dangerous to others	2	4	1	2	*	1	b	5

*Less than 0.5%.

[a]This column represents the proportion of the entire sample who cited each reason in response to any of the preceding seven items, irrespective of whether or not they classified the item as mentally ill.

[b]This category was not separately coded for "nervous breakdown."

TABLE 28--Continued

Reason	Proportion Giving Each Reason							
	Respondents Not Classifying Given Behavior as Mental Illness							Any One of Preceding[a]
	"Frank Jones" (Paranoid)	"Betty Smith" (Simple Schizophrenic)	"Bill Williams" (Alcoholic)	"George Brown" (Anxiety Neurotic)	"Bobby Grey" (Conduct Disturbance)	"Mary White" (Compulsive-Phobic)	"Nervous Breakdown"	
ITS CAUSAL IMPLICATIONS								
Behavior is caused by, symptomatic of, physical agent, disorder or illness	3	3	13	4	*	*	30	29
Behavior is caused by, symptomatic of, malfunctioning of nervous system	1	*	*	1	*	*	12	7
Organic damage to, deterioration of, brain is not present	1	*	*	*	1	*	b	1
Behavior is caused by, symptomatic of, faulty character, moral weakness, lack of will power (it can and should be controlled by the individual)	6	4	16	9	1	3	4	23
Responsibility for the behavior is attributable to others	*	5	1	*	18	*	b	19
Behavior is ingrained in the individual, caused by, symptomatic of, (irreversible) temperament or conditioning	3	7	2	2	3	1	b	11
Behavior is caused by other or unspecified environmental, external, realistic, causally-adequate, difficulties	9	5	2	4	7	1	7	17
Behavior is anomolous, because individual's youthfulness makes it difficult to determine responsibility or ingrainedness	-	1	-	-	4	*	b	4

TABLE 28--Continued

Reason	Proportion Giving Each Reason							
	Respondents Not Classifying Given Behavior as Mental Illness							Any One of Preceding[a]
	"Frank Jones" (Paranoid)	"Betty Smith" (Simple Schizophrenic)	"Bill Williams" (Alcoholic)	"George Brown" (Anxiety Neurotic)	"Bobby Grey" (Conduct Disturbance)	"Mary White" (Compulsive-Phobic)	"Nervous Breakdown"	
ITS TREATMENT IMPLICATIONS								
Condition is controllable by lay, interpersonal, psychological measures	4	12	5	2	19	1	b	26
Condition is controllable by lay, commonsense, physical measures	1	*	*	3	*	*	6	6
Condition is controllable by corporal punishment	1	*	1	*	6	*	b	6
Condition is controllable by medical treatment	1	1	1	2	*	*	b	3
Condition is self-limiting, self-correcting; no countermeasures are needed	1	4	1	1	11	1	b	14
Condition is temporary, easily recovered from, other or unspecified	5	4	3	2	2	1	13	15
Unclassifiable, simple counter-assertion that the behavior is a manifestation of emotional makeup, personality or character	10	7	8	6	2	3	b	1
Don't know reasons	2	1	1	1	1	*	2	*
Reasons too vague to classify	3	2	3	1	1	1	5	1
No reason given	25	10	10	7	5	3	19	5
Total per cent[c]	113	113	115	113	131	109	114	304
Number	867	2,337	2,524	2,891	3,037	3,289	1,849	3,531

[c]Totals exceed 100% because some respondents mentioned more than one reason.

TABLE 29

REASONS FOR CLASSIFYING MENTAL ILLNESS AS SERIOUS

Reason	Proportion Giving Each Reason						
	Respondents Who Classified Given Person as Seriously Mentally-Ill						Any One of Preceding[a]
	"Frank Jones" (Paranoid)	"Betty Smith" (Simple Schizophrenic)	"Bill Williams" (Alcoholic)	"George Brown" (Anxiety Neurotic)	"Bobby Grey" (Conduct Disturbance)	"Mary White" (Compulsive-Phobic)	
ITS CHARACTER							
Person is (will or may become) physically dangerous to others	69	4	12	9	6	4	42
Person is (will or may become) suicidal, physically dangerous to himself	7	5	4	6	1	4	6
Person is (will or may become) uncontrolled, irrational, irresponsible, unpredictable, other or unspecified	5	1	12	4	2	4	6
Person is adversely affecting (will or may adversely affect) the lives of specific other persons	3	5	37	9	6	-	11
Person is (will or may become) a deleterious influence on society, generally	2	8	12	1	58	2	9
Person is damaging (will or may damage) his own physical health	*	2	17	9	-	4	5
Illness is impairing, spoiling (will or may spoil) affected person's life, other or unspecified	5	30	26	17	17	4	14
Illness is (will or may become) psychosis	8	16	9	17	3	4	10
Person is (will or may become) unable to function, out of touch with reality	2	6	3	5	*	17	3
Any mental illness is serious	2	5	1	10	2	6	3

*Less than 0.5%.

[a]This column represents the proportion of the entire sample who cited each reason in response to any of the preceding six items, irrespective of whether or not they classified the item as seriously mentally-ill.

TABLE 29--Continued

Reason	Proportion Giving Each Reason						
	Respondents Who Classified Given Person as Seriously Mentally-Ill						Any One of Preceding[a]
	"Frank Jones" (Paranoid)	"Betty Smith" (Simple Schizophrenic)	"Bill Williams" (Alcoholic)	"George Brown" (Anxiety Neurotic)	"Bobby Grey" (Conduct Disturbance)	"Mary White" (Compulsive-Phobic)	
ITS TREATMENT IMPLICATIONS							
Treatment is needed; condition must be caught, cured, controlled	17	24	13	15	27	17	23
Brain is (may or will become) (irreversibly) damaged, affected	1	1	4	1	*	-	2
Illness is (may or will become) incurable, unalterable, other or unspecified	5	10	11	6	9	6	9
Illness is (may or will become) more serious, more difficult to cure, other or unspecified	3	7	7	16	7	26	8
Don't know reasons	1	2	*	2	1	4	*
Reasons too vague to classify	3	9	2	6	1	13	2
No reasons given	1	1	1	1	1	-	29
Total per cent[b]	134	136	171	134	141	115	182
Number	1,892	569	730	220	308	47	3,531

[b]Totals exceed 100% because some respondents mentioned more than one reason.

TABLE 30

REASON FOR NOT CLASSIFYING MENTAL ILLNESS AS SERIOUS

Reason	Proportion Giving Each Reason						
	Respondents Who Classified Given Person as Not Seriously Mentally-Ill						Any One of Preceding[a]
	"Frank Jones" (Paranoid)	"Betty Smith" (Simple Schizophrenic)	"Bill Williams" (Alcoholic)	"George Brown" (Anxiety Neurotic)	"Bobby Grey" (Conduct Disturbance)	"Mary White" (Compulsive-Phobic)	
ITS CHARACTER							
Person is not dangerous, harmful to others	8	22	11	14	3	14	10
Person is not (completely) irrational, uncontrolled, other or unspecified	4	2	3	2	1	6	2
Functioning is not (seriously) impaired	1	1	-	12	-	27	4
Symptoms are widespread, commonplace	2	2	1	8	4	9	3
Illness is not (will not become) psychosis	2	2	2	1	-	2	1
ITS TREATMENT IMPLICATIONS							
Condition can be cured, controlled, by lay interpersonal, psychological measures	9	26	19	9	28	7	13
Condition can be cured, controlled, by will-power, self-help	9	8	25	18	1	17	10
Condition can be cured, controlled, by psychiatric treatment	13	12	6	10	12	6	10
Condition can be cured, controlled, by medical treatment	6	4	4	5	2	1	5
Condition can be cured, controlled, by lay, commonsense physical measures	3	*	-	4	-	-	2
Condition can be cured, controlled, by remedying the immediate, objective, external cause	2	1	1	3	3	1	2
Condition is self-limiting, self-correcting; no countermeasures are needed	5	9	2	8	31	13	7
Condition can be cured, controlled, overcome, other or unspecified	21	14	22	13	19	10	14
Don't know reason	1	*	1	*	-	1	*
Reasons too vague to classify	7	4	5	4	4	7	2
No reasons given	18	12	13	13	13	8	48
Total per cent[b]	111	119	115	124	121	129	133
Number	772	625	277	420	186	195	3,531

*Less than 0.5%.

[a]This column represents the proportion of the entire sample who cited each reason in response to any of the preceding six items, irrespective of whether or not they classified the item as not seriously mentally-ill.

[b]Totals exceed 100% because some respondents mentioned more than one reason.

TABLE 31

SUMMARY OF TYPE OF PROBLEM SEEN IN SIX EXAMPLES OF HUMAN BEHAVIOR

Problem Type	Proportion Classifying Given Person as Each Problem Type					
	"Frank Jones" (Paranoid)	"Betty Smith" (Simple Schizophrenic)	"Bill Williams" (Alcoholic)	"George Brown" (Anxiety Neurotic)	"Bobby Grey" (Conduct Disturbance)	"Mary White" (Compulsive-Phobic)
ALL RESPONDENTS						
Mentally ill	75	34	29	18	14	7
Not mentally ill						
Action required[a]	11	20	50	34	63	6
Psychiatric	1	1	*	1	1	*
Medical	*	1	1	2	*	*
Physical	1	3	10	7	*	1
Practical	4	7	4	14	35	2
Lay psychological	1	7	4	2	13	1
Moral, self-help	5	3	34	11	16	3
Action not required	5	34	12	32	18	79
Problem too trivial	1	4	1	1	5	1
Behavior non-problematic	1	11	4	10	4	37
Personality with which "nothing wrong"	3	19	7	21	9	41
Action not referred to	9	12	9	16	5	8
Nervous, emotional or other than physical illness	1	1	3	5	*	1
Personality with which "something wrong"	6	11	6	9	3	6
No discussion of person	2	*	*	2	2	1
Total per cent	100	100	100	100	100	100
Number	3,531	3,531	3,531	3,531	3,531	3,531

*Less than 0.5%.

[a]Totals for this category are smaller than the sum of its sub-categories because a few respondents mentioned more than one type of action.

TABLE 31--Continued

Problem Type	Proportion Classifying Given Person as Each Problem Type					
	"Frank Jones" (Paranoid)	"Betty Smith" (Simple Schizophrenic)	"Bill Williams" (Alcoholic)	"George Brown" (Anxiety Neurotic)	"Bobby Grey" (Conduct Disturbance)	"Mary White" (Compulsive-Phobic)
RESPONDENTS NOT CLASSIFYING PERSON AS MENTALLY ILL						
Action required[a]	46	31	71	42	74	7
Psychiatric	2	2	1	1	1	*
Medical	2	1	1	2	*	*
Physical	6	4	14	9	*	1
Practical	15	11	6	17	41	2
Lay psychological	3	11	5	2	15	1
Moral, self-help	20	5	48	13	18	3
Action not required	19	51	16	39	20	84
Problem too trivial	3	6	1	1	6	1
Behavior non-problematic	4	17	5	13	4	39
Personality with which "nothing wrong"	12	28	10	25	10	44
Action not referred to	35	18	13	19	6	9
Nervous, emotional or other than physical illness	6	1	4	6	*	1
Personality with which "something wrong"	22	17	8	11	4	7
No discussion of person	7	*	1	2	2	1
Total per cent	100	100	100	100	100	100
Number	867	2,237	2,524	2,891	3,037	3,289

TABLE 32

TREATMENT RECOMMENDATIONS FOR SIX EXAMPLES OF HUMAN BEHAVIOR, WHEN CLASSIFIED AS MENTALLY ILL

Recommended Treatment	Proportion of Those Classifying Given Person as Mentally-Ill Who Recommended Each Treatment					
	"Frank Jones" (Paranoid)	"Betty Smith" (Simple Schizophrenic)	"Bill Williams" (Alcoholic)	"George Brown" (Anxiety Neurotic)	"Bobby Grey" (Conduct Disturbance)	"Mary White" (Compulsive-Phobic)
Action required[a]						
Psychiatric	8	9	4	9	10	6
Medical	3	3	3	4	2	1
Physical	1	*	2	4	*	*
Practical	1	1	*	2	4	*
Lay psychological	3	15	9	6	13	5
Moral, self-help	3	5	11	14	1	14
Type unspecified	15	16	12	13	17	11
	33	47	38	45	45	36
Action not required	2	5	1	8	8	15
Action not referred to	65	48	61	47	47	49
Total per cent	100	100	100	100	100	100
Number	2,664	1,194	1,007	640	494	242

* *Less than 0.5%.

[a]Totals for this category are smaller than the sum of its sub-categories because a few respondents mentioned more than one type of action.

TABLE 33

NUMBER OF CAUSAL FACTORS USED IN EXPLAINING SIX EXAMPLES OF HUMAN BEHAVIOR

Number of Different Causal Factors Used	Proportion Using Each Number of Causal Factors among Those Explaining Indicated Number of Examples						
	One Example	Two Examples	Three Examples	Four Examples	Five Examples	Six Examples	All Respondents
One	86	18	5	1	*	*	6
Two	12	63	36	19	8	4	18
Three	2	18	44	41	36	28	33
Four	-	1	14	29	38	36	27
Five	-	*	1	9	16	26	13
Six	-	-	*	1	2	6	2
Total percent	100	100	100	100	100	100	100[a]
Number	126	301	477	795	989	800	3,531
Mean number of different causes used for:							
Each example explained	1.2	1.2	1.2	1.3	1.3	1.4	1.3
All examples explained	1.2	2.1	2.8	3.3	3.7	4.0	3.3
Mean number of examples explained by same cause	1.0	1.1	1.3	1.6	1.8	2.1	1.7

*Less than 0.5%.

[a]Includes one percent who did not discuss any example in causal terms.

TABLE 34

TYPES OF CAUSAL FACTORS USED IN EXPLAINING SIX EXAMPLES OF HUMAN BEHAVIOR

Cause	Proportion of Respondents Who Explained Indicated Number of Examples Using Each Causal Factor						
	One Example	Two Examples	Three Examples	Four Examples	Five Examples	Six Examples	All Respondents
Organic factors[a]	(25)	(35)	(46)	(53)	(60)	(61)	(52)
Affecting brain, nervous system	17	23	33	39	43	46	38
General or diffuse	10	15	19	24	33	37	27
Personality factors[a]	20	28	37	43	46	53	43
Innate	(17)	(22)	(30)	(29)	(30)	(30)	(28)
Ambiguous	(3)	(7)	(12)	(20)	(21)	(31)	(20)
Voluntaristic	(-)	(-)	(*)	(1)	(1)	(1)	(1)
Social factors[a]	(70)	(95)	(97)	(99)	(100)	(100)	(98)
External environment, circumstances	21	40	64	75	88	92	75
Direct, equivalent conditioning	37	67	81	92	95	98	88
Psychodynamic relationships	20	38	46	58	66	75	59
Total percent[b]	125	211	280	331	371	401	330[c]
Number	126	301	477	795	989	800	3,531

*Less than 0.5%.

[a]Totals for this sub-group are smaller than the sum of its subcategories because a respondent may have used more than one subcategory.

[b]These are the totals of the six original causal categories shown in bold face. Totals exceed 100% because most respondents used more than one of the six categories.

[c]Includes one percent who did not discuss any example in causal terms.

TABLE 55

RELATION OF PRIOR CAUSAL USAGE TO MODE OF CAUSAL EXPLANATION OF HUMAN BEHAVIOR

Cause and Previous Usage	Proportion Using Each Cause for Indicated Example among Those Explaining That Example and Having Each Previous Causal Usage[a]				
	"Betty Smith" (Simple Schizophrenic)	"George Brown" (Anxiety Neurosis)	"Bill Williams" (Alcoholic)	"Mary White" (Compulsive Phobic)	"Bobby Grey" (Conduct Disturbance)
Organic proccesses directly affecting brain, nervous system					
Not previously used	5 (2,208)	5 (1,741)	23 (1,628)	1 (1,351)	2 (1,851)
Previously used once	19 (633)	10 (531)	31 (555)	4 (564)	3 (833)
Previously used twice		21 (83)	36 (103)	7 (176)	5 (257)
Previously used three or more times			c (16)	13 (38)	14 (64)
Diffuse physical processes					
Not previously used	4 (2,512)	21 (1,995)	2 (1,691)	2 (1,562)	* (2,179)
Previously used once	12 (329)	36 (331)	5 (502)	2 (469)	1 (656)
Previously used twice		55 (29)	4 (100)	7 (85)	2 (145)
Previously used three or more times			c (9)	c (13)	4 (25)
Innate personality, will, choice					
Not previously used	8 (2,447)	19 (1,916)	11 (1,617)	5 (1,414)	8 (1,901)
Previously used once	11 (394)	27 (409)	14 (575)	6 (569)	11 (862)
Previously used twice		53 (30)	15 (98)	12 (125)	16 (203)
Previously used three or more times			c (12)	c (21)	38 (39)
External environment, circumstances					
Not previously used	19 (1,964)	53 (1,351)	58 (890)	4 (503)	6 (728)
Previously used once	27 (877)	60 (826)	63 (887)	4 (750)	9 (1,064)
Previously used twice		64 (178)	66 (435)	4 (599)	10 (781)
Previously used three or more times			74 (90)	4 (277)	15 (432)
Direct, equivalent conditioning					
Not previously used	59 (1,990)	3 (872)	26 (833)	82 (637)	58 (573)
Previously used once	70 (851)	3 (1,030)	31 (1,003)	89 (825)	65 (942)
Previously used twice		5 (453)	37 (449)	93 (526)	69 (881)
Previously used three or more times			c (17)	98 (141)	71 (609)
Other psychodynamic relationships					
Not previously used	28 (2,498)	13 (1,575)	12 (1,430)	3 (1,166)	35 (1,679)
Previously used once	47 (343)	19 (658)	24 (659)	4 (649)	49 (901)
Previously used twice		35 (122)	33 (178)	6 (236)	52 (313)
Previously used three or more times			54 (35)	13 (78)	80 (112)

*Less than 0.5%.

[a]The examples are shown in this table in the order in which they were presented to the public, while earlier tables have shown them in order of the frequency with which they were classed as mentally-ill. "Frank Jones" was the first example presented and is, therefore, omitted, since no relevant discussion could precede it.

[b]The number in parentheses is the number on which the percentage is based. It may be read, as in this first instance, that there were 2,208 people who causally explained "Betty Smith" who had not previously used direct nervous system processes in explaining the preceding example, "Frank Jones." Of this group, 5% offered this explanation of "Betty Smith."

[c]Too few cases to report a percentage.

TABLE 36

RELATION OF PRIOR CAUSAL USAGE TO ABILITY TO EXPLAIN HUMAN BEHAVIOR

Cause	Mean Number of Subsequent Examples Explained by Respondents Explaining Indicated Example in Each Way[a]				
	"Frank Jones" (Paranoid)	"Betty Smith" (Simple Schizophrenic)	"George Brown" (Anxiety Neurotic)	"Bill Williams" (Alcoholic)	"Mary White" (Compulsive Phobic)
Organic processes directly affecting brain, nervous system					
Used for this example	3.7 (767)[b]	2.9 (235)	2.3 (148)	1.4 (665)	0.9 (50)
Not used for this example[c]	3.8 (1,909)	2.9 (2,606)	2.2 (2,207)	1.5 (1,737)	0.9 (2,079)
Diffuse physical processes					
Used for this example	3.7 (386)	2.9 (141)	2.2 (542)	1.5 (54)	0.9 (39)
Not used for this example[c]	3.8 (2,290)	2.9 (2,700)	2.2 (1,813)	1.5 (2,248)	0.9 (2,090)
Innate personality, will, choice					
Used for this example	3.8 (470)	2.8 (262)	2.2 (515)	1.5 (330)	0.9 (203)
Not used for this example[c]	3.8 (2,206)	2.9 (2,579)	2.3 (1,840)	1.5 (1,972)	0.9 (1,926)
External environment, circumstances					
Used for this example	4.0 (953)	3.0 (1,741)	2.4 (80)	1.6 (674)	0.9 (1,826)
Not used for this example[c]	3.6 (1,723)	2.8 (1,100)	2.2 (2,275)	1.4 (1,628)	0.9 (303)

[a]The examples are shown in this table in the order in which they were presented to the public. "Bobby Grey," the last example presented, is omitted because no relevant discussion could follow it.

[b]The number in parentheses is the number of people using a specified cause for the particular example, the number on which the mean is based.

[c]Includes only people who used some causal explanation for the example.

TABLE 36--Continued

Cause	Mean Number of Subsequent Examples Explained by Respondents Explaining Indicated Example in Each Way[a]				
	"Frank Jones" (Paranoid)	"Betty Smith" (Simple Schizophrenic)	"George Brown" (Anxiety Neurotic)	"Bill Williams" (Alcoholic)	"Mary White" Compulsive-Phobic)
Direct, equivalent conditioning					
Used for this example	4.0 (953)	3.0 (1,741)	2.4 (80)	1.6 (674)	0.9 (1,826)
Not used for this example[c]	3.6 (1,723)	2.8 (1,100)	2.2 (2,275)	1.4 (1,628)	0.9 (303)
Other psychodynamic relationships					
Used for this example	4.1 (376)	3.0 (852)	2.3 (373)	1.6 (402)	0.9 (84)
Not used for this example[c]	3.7 (2,300)	2.8 (1,989)	2.2 (1,982)	1.5 (1,900)	0.9 (2,045)
Summary:					
Social causes used for this example	3.9 (1,953)	2.9 (2,538)	2.3 (1,649)	1.6 (1,725)	0.9 (1,929)
No social causes used for this example[c]	3.5 (723)	2.6 (303)	2.1 (706)	1.4 (577)	0.9 (200)
No causes used for this example[d]	2.9 (812)	2.3 (647)	1.8 (1,133)	1.4 (1,186)	0.8 (1,359)

[d]Omits the few respondents who never offered any causal explanation of any example.

TABLE 37

SUMMARY OF CAUSAL EXPLANATIONS OF HUMAN BEHAVIOR, IN RELATION TO JUDGMENT OF THE PROBLEMATICAL CHARACTER OF THE BEHAVIOR

Cause	Proportion of Examples Explained by Each Causal Factor among Examples Classified in Indicated Way			
	Mental Illness	Something Else Wrong[a]	Nothing Wrong	Total
ALL EXAMPLES				
Organic processes directly affecting brain, nervous system	17	8	3	9
Diffuse physical processes	8	6	3	6
Innate personality, will, choice	10	11	9	10
External environment, circumstances	29	24	17	23
Direct, equivalent conditioning	28	33	40	34
Other psychodynamic relationships	16	19	13	16
Causes too vague to classify	2	1	2	2
Don't know to causes	9	10	7	8
Descriptive answers	15	14	23	18
Total per cent[b]	134	126	117	126
Number of examples	6,241	6,819	8,126	21,186
EXAMPLES WHICH WERE CAUSALLY EXPLAINED				
Organic processes directly affecting brain, nervous system	23	11	4	12
Diffuse physical processes	10	8	5	8
Innate personality, will, choice	14	13	13	14
External environment, circumstances	39	32	25	32
Direct, equivalent conditioning	37	45	58	47
Other psychodynamic relationships	22	26	18	22
Total per cent[b]	145	135	123	135
Number of examples	4,622	5,100	5,584	15,306

[a] Includes both people who said it was not mental illness and people who were undecided about whether or not it was mental illness.

[b] Totals exceed 100% because some respondents referred to more than one type of cause in connection with a single example.

TABLE 38

SUMMARY OF CATEGORIZATIONS OF BEHAVIOR IN RELATION TO MODE OF CAUSAL EXPLANATION

Category	Proportion of Examples Explained by Indicated Cause That Were Categorized in Each Way							
	Direct Brain, Nervous System Processes	Diffuse Physical Factors	Innate Personality, Will, Choice	External Environment, Circumstances	Direct Equivalent Conditioning	Psychodynamic Relationships	No Causal Explanation	Total
Mental illness	57	41	32	37	24	30	27	29
Nervous, emotional or other illness	4	10	2	4	1	1	3	3
Physical illness	6	9	1	1	*	1	1	1
Temperament, conditioning, personality . . .	15	23	44	32	54	42	47	45
Bad will, defective character	11	2	15	11	9	12	12	10
Response to circumstances	2	7	*	11	10	11	*	7
Other and mixed categories	5	8	6	4	2	3	1	2
No classification . . .	-	-	-	-	-	-	9	3
Total percent . .	100	100	100	100	100	100	100	100
Number of examples	1,844	1,185	2,071	4,808	7,219	3,366	5,880	21,186

*Less than 0.5%.

TABLE 39

RELATION OF ACTION ORIENTATION TO PROBLEMATIC CHARACTER OF HUMAN BEHAVIOR

Action Reference	Proportion Making Each Reference to Action among Those With Indicated View of Problematic Status of Example															
	"Frank Jones" (Paranoid)		"Betty Smith" (Simple Schizophrenic)		"Bill Williams" (Alcoholic)		"George Brown" (Anxiety Neurotic)		"Bobby Grey" (Conduct Disturbance)		"Mary White" (Compulsive-Phobic)		All Examples[a]		Any Example[b]	
	Something Wrong	Nothing Wrong	Something Wrong	Nothing Wrong	Something Wrong	Nothing Wrong	Something Wrong	Nothing Wrong	Something Wrong	Nothing Wrong	Something Wrong	Nothing Wrong	Something Wrong	Nothing Wrong	Something Wrong	Nothing Wrong
ALL RESPONDENTS																
No action needed	3	2	16	18	5	5	11	15	10	11	36	40	10	21	32	46
Self-help needed	7	24	6	4	31	55	15	12	13	19	8	2	13	15	39	32
Other action needed . .	30	22	37	17	31	15	37	29	55	52	16	3	36	22	66	47
No reference to action .	60	52	41	61	33	25	37	44	22	18	40	55	41	42	11	17
Total percent . .	100	100	100	100	100	100	100	100	100	100	100	100	100	100	148	142
Number	3,348	183	2,551	980	2,543	988	1,863	1,668	1,857	1,674	897	2,634	13,059	8,127	3,470	3,051

[a]These percentages are based on the total number of examples classified as having something (or nothing) wrong. They are therefore an average of the action references in the six preceding examples, weighted by the frequency with which each example was classified as having something (or nothing) wrong.

[b]These are the percentages of all respondents who classified one or more examples as having something (or nothing) wrong who made each kind of action reference for any example so classified. "No reference to action" therefore includes only those who did not refer to action in connection with any of the examples they classified in the particular category. The sum of the three types of action references (and, consequently, the total percent) exceed the proportion of people referring to action because it was possible for a single respondent to make different types of action references for different examples.

TABLE 39—Continued

Action Reference	Proportion Making Each Reference to Action among Those With Indicated View of Problematic Status of Example															
	"Frank Jones" (Paranoid)		"Betty Smith" (Simple Schizophrenic)		"Bill Williams" (Alcoholic)		"George Brown" (Anxiety Neurotic)		"Bobby Grey" (Conduct Disturbance)		"Mary White" (Compulsive-Phobic)		All Examples[a]		Any Example[b]	
	Something Wrong	Nothing Wrong	Something Wrong	Nothing Wrong	Something Wrong	Nothing Wrong	Something Wrong	Nothing Wrong	Something Wrong	Nothing Wrong	Something Wrong	Nothing Wrong	Something Wrong	Nothing Wrong	Something Wrong	Nothing Wrong
RESPONDENTS REFERRING TO ACTION																
No action needed	9	5	27	46	7	7	18	26	12	13	60	88	18	36	35	55
Self-help needed	17	49	10	9	46	73	23	15	17	24	13	5	22	26	43	39
Other action needed . .	74	46	63	45	47	20	59	59	71	63	27	7	60	38	74	57
Total percent . .	100	100	100	100	100	100	100	100	100	100	100	100	100	100	152	151
Number	1,347	87	1,505	385	1,710	742	1,176	928	1,455	1,376	542	1,186	7,735	4,704	3,102	2,533

TABLE 40

RELATION OF ACTION ORIENTATION TO CONCERN WITH CAUSAL EXPLANATION OF HUMAN BEHAVIOR

Action Orientation	Proportion of Those with Each Action Orientation toward Indicated Example Who Made No Reference to Causation						
	"Frank Jones" (Paranoid)	"Betty Smith" (Simple Schizophrenic)	"Bill Williams" (Alcoholic)	"George Brown" (Anxiety Neurotic)	"Bobby Grey" (Conduct Disturbance)	"Mary White" (Compulsive-Phobic)	All Examples[a]
Nothing wrong							
Behavior acceptable, or no action needed	b (4)[c]	29 (178)	46 (54)	41 (249)	52 (181)	40 (1,044)	41 (1,710)
Behavior voluntary, or self-help needed	39 (44)	21 (73)	36 (607)	45 (214)	12 (350)	45 (82)	31 (1,370)
No reference to action dimension . . .	22 (95)	13 (560)	26 (195)	31 (732)	11 (283)	26 (1,430)	23 (3,295)
Behavior requires corrective action .	5 (40)	7 (169)	14 (132)	8 (473)	4 (860)	17 (78)	7 (1,752)
Something wrong							
Behavior acceptable, or no action needed	11 (119)	7 (406)	21 (122)	22 (210)	13 (179)	21 (326)	15 (1,362)
Behavior voluntary, or self-help needed	21 (233)	10 (183)	29 (903)	24 (275)	12 (261)	36 (73)	24 (1,928)
No reference to action dimension . . .	11 (1,997)	9 (1,025)	28 (758)	20 (685)	10 (394)	26 (355)	15 (5,214)
Behavior requires corrective action .	9 (999)	5 (937)	21 (760)	11 (693)	4 (1,023)	17 (143)	10 (4,555)

[a]These percentages are based on the total number of examples in the particular classification. They are, therefore, an average of the six preceding examples, in which each example is weighted proportionally to the frequency of that category for the example.

[b]Too few cases to report a percentage.

[c]The number in parentheses is the number of persons (or, for the "total" column, the number of examples) with this action orientation toward the example and is, therefore, the base of the percentage.

TABLE 41

CRITERIA USED IN DETERMINING MENTAL ILLNESS

Criterion[a]	Proportion Using Each Criterion for Indicated Example							Total	
	"Frank Jones" (Paranoid)	"Betty Smith" Schizophrenic)	"Bill Williams" (Alcoholic)	"George Brown" (Anxiety Neurotic)	"Bobby Grey" (Conduct Disturbance)	"Mary White" (Compulsive-Phobic)	"Nervous Breakdown"	Examples[b]	Respondents[c]
ALL RESPONDENTS									
Single criterion									
Character	52	49	45	59	35	84	21	50	8
Cause	14	14	21	14	18	4	43	18	1
Treatment	2	8	4	5	15	2	7	6	-
Multiple criteria									
Character and cause	8	5	9	5	5	2	6	6	38
Character and treatment	1	3	1	2	10	1	1	3	8
Cause and treatment	1	3	2	1	6	*	3	2	1
Character, cause and treatment	*	1	*	*	2	*	*	*	44
Vague, unclassifiable or don't know	15	10	11	9	5	4	10	9	-
No explanation given	7	7	7	5	4	3	9	6	-
Total per cent	100	100	100	100	100	100	100	100	100
Number	3,531	3,531	3,531	3,531	3,531	3,531	3,531	24,717	3,531

*Less than 0.5%.

[a]The criterion categories are defined in Tables 27-28, where the concrete reasons given for regarding the example as mentally-ill or as not mentally-ill are classified under these major headings.

[b]These percentages are based on the total number of examples in the particular classification. They are, therefore, an average of the seven preceding examples.

[c]These figures are the proportion of respondents who made use of the indicated criteria at any point in their discussions. Since it is, thus a composite of the seven separate discussions, a respondent may never have used, for any one example, the particular combination he is classified into here. It, thus, represents the range of criteria, in the course of a respondent's discussion.

TABLE 41--Continued

Criterion[a]	Proportion Using Each Criterion for Indicated Example							Total	
	"Frank Jones" (Paranoid)	"Betty Smith" (Simple Schizophrenic)	"Bill Williams" (Alcoholic)	"George Brown" (Anxiety Neurotic)	"Bobby Grey" (Conduct Disturbance)	"Mary White" (Compulsive-Phobic)	"Nervous Breakdown"	Examples[b]	Respondents[c]
RESPONDENTS USING CLASSIFIABLE CRITERION									
Single criterion									
Character	66	59	55	68	39	91	26	58	8
Cause	18	18	25	17	20	4	53	22	1
Treatment	3	10	5	5	16	2	8	7	-
Multiple criteria									
Character and cause . . .	10	6	11	6	6	2	7	7	38
Character and treatment .	1	3	2	2	11	1	2	3	8
Cause and treatment . . .	1	3	2	1	6	*	4	2	1
Character, cause and treatment	1	1	*	1	2	*	*	1	44
Total per cent	100	100	100	100	100	100	100	100	100
Number	2,751	2,936	2,902	3,048	3,219	3,296	2,861	21,011	3,531

RELATION OF DESCRIPTIVE CRITERIA TO PERCEPTION OF MENTAL ILLNESS IN SIX EXAMPLES OF HUMAN BEHAVIOR

Person or Type	Proportion of Group Using Indicated Criterion Who Classified Each Example as Mentally-Ill		
	Emotional-Functional Deviancy Included	Cognitive-Control Deviancy Only	General Deviancy Only
ALL RESPONDENTS			
"Frank Jones" (Paranoid)	89	72	55
"Betty Smith" (Simple Schizophrenic)	52	19	15
"Bill Williams" (Alcoholic)	39	25	12
"George Brown" (Anxiety Neurotic)	28	11	7
"Bobby Grey" (Conduct Disturbance)	19	13	6
"Mary White" (Compulsive-Phobic)	11	4	2
At least one of above	96	80	68
Four-question summary:			
Personality disorder (and all others below) included	6	1	1
Neurosis (and all others below) included	14	5	2
Limited to psychosis, generally	26	10	10
Limited to violent psychosis	33	49	39
No apparent recognition	6	26	42
Usage not consistently classifiable	15	9	6
Total per cent	100	100	100
Number	1,666	951	884
RESPONDENTS WHOSE GENERAL IMPRESSION OF MENTAL ILLNESS CONSISTENTLY INCLUDED NON-PSYCHOTIC SYNDROMES			
"Frank Jones" (Paranoid)	92	82	65
"Betty Smith" (Simple Schizophrenic)	58	22	20
"Bill Williams" (Alcoholic)	50	34	19
"George Brown" (Anxiety Neurotic)	35	19	13
"Bobby Grey" (Conduct Disturbance)	23	18	8
"Mary White" (Compulsive-Phobic)	15	3	3
At least one of above	98	90	70
Four-question summary:			
Personality disorder (and all others below) included	9	2	1
Neurosis (and all others below) included	16	8	4
Limited to psychosis, generally	27	12	13
Limited to violent psychosis	27	51	38
No apparent recognition	4	17	34
Usage not consistently classifiable	17	10	10
Total per cent	100	100	100
Number	584	211	203
RESPONDENTS WHOSE GENERAL IMPRESSION OF MENTAL-ILLNESS DID NOT CONSISTENTLY INCLUDE NON-PSYCHOTIC SYNDROMES			
"Frank Jones" (Paranoid)	87	67	52
"Betty Smith" (Simple Schizophrenic)	49	18	13
"Bill Williams" (Alcoholic)	32	21	10
"George Brown" (Anxiety Neurotic)	23	9	5
"Bobby Grey" (Conduct Disturbance)	16	11	5
"Mary White" (Compulsive-Phobic)	9	4	2
At least one of above	95	77	67
Four-question summary:			
Personality disorder (and all others below) included	4	1	1
Neurosis (and all others below) included	12	3	1
Limited to psychosis, generally	25	10	9
Limited to violent psychosis	38	48	38
No apparent recognition	7	29	46
Usage not consistently classifiable	14	9	5
Total per cent	100	100	100
Number	1,082	770	681

TABLE 43

TYPES OF SPECIFIC ACTION RECOMMENDED FOR PROBLEMATIC AND NON-PROBLEMATIC HUMAN BEHAVIOR

Specific Action Recommendation	Mental Illness	Something Else Wrong[a]	Nothing Wrong	Total
"FRANK JONES" (PARANOID)				
Psychiatric	44	6	1	26
Medical	18	4	1	11
Physical	7	13	12	10
Practical	5	34	29	18
Lay psychological	18	9	2	13
Moral, self-help	20	41	56	31
Total per cent[b]	112	107	101	109
Number making specific recommendations	466	312	84	862
"BETTY SMITH" (SIMPLE SCHIZOPHRENIC)				
Psychiatric	30	9	3	15
Medical	11	4	-	5
Physical	2	16	5	9
Practical	3	31	41	24
Lay psychological	47	33	37	39
Moral, self-help	16	16	19	17
Total per cent[b]	109	109	105	109
Number making specific recommendations	373	495	221	1,089
"BILL WILLIAMS" (ALCOHOLIC)				
Psychiatric	17	1	*	3
Medical	12	2	*	3
Physical	8	28	5	18
Practical	2	9	9	8
Lay psychological	33	8	7	11
Moral, self-help	43	60	81	65
Total per cent[b]	115	108	102	108
Number making specific recommendations	266	1,079	701	2,046
"GEORGE BROWN" (ANXIETY NEUROTIC)				
Psychiatric	27	4	1	6
Medical	13	7	2	6
Physical	12	28	15	20
Practical	8	31	48	35
Lay psychological	19	5	5	7
Moral, self-help	42	32	32	34
Total per cent[b]	121	107	103	108
Number making specific recommendations	207	578	628	1,413
"BOBBY GREY" (CONDUCT DISTURBANCE)				
Psychiatric	34	2	1	3
Medical	6	1	-	1
Physical	1	1	1	1
Practical	14	55	56	53
Lay psychological	47	22	18	22
Moral, self-help	5	23	27	24
Total per cent[b]	107	104	103	104
Number making specific recommendations	139	1,038	1,193	2,370
"MARY WHITE" (COMPULSIVE-PHOBIC)				
Psychiatric	24	11	4	11
Medical	3	5	1	3
Physical	2	13	7	8
Practical	2	30	25	21
Lay psychological	21	10	10	12
Moral, self-help	53	38	53	47
Total per cent[b]	105	107	100	102
Number making specific recommendations	62	134	123	289

*Less than 0.5%.

[a]This category includes both people who said it was not mental illness and people who were undecided about whether or not it was mental illness.

[b]Totals exceed 100% because people sometimes made more than one type of recommendation.

fc

TABLE 43--Continued

Specific Action Recommendation	Mental Illness	Something Else Wrong[a]	Nothing Wrong	Total
SUMMARY				
ALL EXAMPLES[c]				
Psychiatric	32	3	1	8
Medical	13	3	*	4
Physical	6	17	5	11
Practical	5	31	40	29
Lay psychological	31	15	13	17
Moral, self-help	26	37	42	37
Total per cent[b]	113	106	101	106
Number of examples for which specific action recommendations were made	1,513	3,606	2,950	8,069
ALL RESPONDENTS MAKING ACTION RECOMMENDATIONS				
Psychiatric	35	5	1	15
Medical	15	4	1	8
Physical	8	25	7	23
Practical	6	43	53	56
Lay psychological	36	22	18	34
Moral, self-help	31	48	51	62
Total per cent[b]	131	147	131	198
Number making specific recommendations	1,121	2,261	1,917	3,295

[c]These percentages are based on the total number of examples in the particular classification. They are, therefore, an average of the six preceding examples, in which each example is weighted proportionally to the frequency of that category for the example.

TABLE 44

TYPES OF LOGICAL CONTRADICTIONS
IN DISCUSSION OF MENTAL ILLNESS

Logical Contradiction	Proportion Making Each Contradiction	
	All Respondents	Respondents Using That Criterion of Mental Illness
CHARACTER		
Behavior is not mental illness because it is not psychosis, but mental illness includes non-psychotic syndromes	9	77
Descriptive criteria for saying it is not mental illness (e.g., lack of functional impairment, lack of irrationality, etc.) are same as criteria used to distinguish non-psychotic mental illness from psychosis	6	25
CAUSAL IMPLICATIONS		
Behavior is not mental illness because its causes are external, environmental, causally-adequate; but external, environmental, causally-adequate factors are given as causes of mental illness	31	92
Behavior is not mental illness because its causes are physical, but physical causes are given as causes of mental illness . .	22	68
Behavior is mental illness because it has no "real" causes, but "real" causes are given as causes of mental illness	16	97
Behavior is not mental illness because it is indicative of character defect controllable by will-power, but character defects are given as distinguishing characteristic or cause of mental illness or self-help is given as treatment of mental illness . . .	19	83
Behavior is not mental illness because it is indicative of malfunctioning of nervous system, but malfunctioning of nervous system is also given as symptom, cause or definition of mental illness	7	81
Behavior is not mental illness because it is result of irreversible conditioning or temperament, but these same factors are given as causes of mental illness	6	52

TABLE 44--Continued

Logical Contradiction	Proportion Making Each Contradiction	
	All Respondents	Respondents Using That Criterion of Mental Illness
TREATMENT IMPLICATIONS		
Behavior is not mental illness because it is curable by some specific measure that is also mentioned as a treatment for mental illness	15	43
Behavior is not mental illness because it is temporary or curable (other), but mental illness is elsewhere referred to as temporary or curable	15	98
Behavior is mental illness because it is incurable, but mental illness is elsewhere described as curable	1	87
No contradictory logic	20	
Total per cent[a]	167	
Number	3,531	

[a]Totals exceed 100% because it was possible for one person to contradict himself in more than one way.

TABLE 45

INCONSISTENCIES IN USAGE OF CONCEPT OF MENTAL ILLNESS IN INTERPRETATIONS OF SIX EXAMPLES OF MENTAL ILLNESS

Type of Inconsistency	Proportion in Each Group
Explicitly self-contradictory	
Referred to "nervous illness" as a category distinct from mental illness in examples, after including it within mental illness in general impression	2
Volunteered "nervous breakdown" as a category of mental illness in examples, but did not classify "nervous breakdown" as mental illness in general impression	1
Used "nervous illness" in examples, both as a category of mental illness and as a category distinct from mental illness	6
Other self-contradictory use of terms	1
Inconsistent with technical criteria	
Volunteered non-psychotic mental illness diagnoses in examples after not including "non-insane" in mental illness	2
Used diagnostic labels with other than technical meaning	14
No inconsistencies in examples	
Previously inconsistent in general impression of mental illness	48
Previously uninformed in general impression of mental illness	3
Previously consistent in general impression of mental illness:	
Consistently limited to psychosis	6
Consistently included non-psychotic syndromes	21
Total per cent[a]	104
Number	3,531

[a] Total exceeds 100% because some persons were inconsistent in their discussion of the examples in more than one way.

TABLE 46

SUMMARY OF INCONSISTENCIES IN ENTIRE DISCUSSION

OF MEANING OF MENTAL ILLNESS

Consistency of Usage	Proportion of All Respondents with Given General Impression of Mental Illness and Each Consistency in Usage			
	Non-Psychotic Syndromes Included in General Impression	Limited to Psychosis Only in General Impression	Mental Deficiency, Non-Mental Illness or No Impression	Total
Inconsistent in general discussion[a]				
Inconsistent in usage in examples[b]				
Contradictory logic[c]	10	2	-	12
No contradictory logic	1	1	-	2
Consistent in usage in examples				
Contradictory logic	30	10	-	40
No contradictory logic	6	2	-	8
Consistent in general discussion				
Inconsistent in usage in examples				
Contradictory logic	5	1	*	6
No contradictory logic	2	*	*	2
Consistent in usage in examples				
Contradictory logic	17	4	1	22
No contradictory logic	4	2	2	8
Total per cent	75	22	3	100
Number	2,642	787	102	3,531

*Less than 0.5%.

[a]Inconsistencies in general discussion are shown in detail in Table 10.

[b]Inconsistencies in usage in examples are shown in detail in Table 45.

[c]Contradictory logic is shown in detail in Table 44.

TABLE 47

RELATION OF RECOGNITION OF REAL PERSONS IN EXAMPLES TO PERCEPTION OF MENTAL ILLNESS IN HUMAN BEHAVIOR

Recognition of Real Persons	Proportion Who Classified Each Example as Mentally-Ill Among Those Who Identified Example With Indicated Persons						
	"Frank Jones" (Paranoid)	"Betty Smith" (Simple Schizophrenic)	"Bill Williams" (Alcoholic)	"George Brown" (Anxiety Neurotic)	"Bobby Grey" (Conduct Disturbance)	"Mary White" (Compulsive-Phobic)	"Nervous Breakdown"
Self	55 (22)[a]	23 (65)	26 (42)	12 (138)	2 (41)	3 (673)	37 (196)
Immediate family[b]	64 (33)	17 (58)	12 (73)	19 (58)	14 (43)	1 (81)	54[c] (274)
All others	77 (163)	35 (213)	32 (265)	20 (122)	18 (122)	10 (96)	
None	76 (3,315)	34 (3,195)	29 (3,151)	18 (3,213)	14 (3,325)	8 (2,681)	45 (3,061)

[a]The number in parentheses is the number of cases on which the percentage is based.

[b]"Immediate family" includes only parents, siblings, spouse and offspring.

[c]Data for immediate family and others are not available separately for "nervous breakdown."

TABLE 48

TREATMENT RECOMMENDATIONS FOR SIX EXAMPLES OF MENTAL ILLNESS, IN RELATION TO ITS SERIOUSNESS

Recommended Treatment	Proportion Recommending Each Treatment, Among Those Taking Indicated Position on the Seriousness of the Example's Mental Illness and Making Some Action Recommendation													
	"Frank Jones" (Paranoid)		"Betty Smith" (Simple Schizophrenic)		"Bill Williams" (Alcoholic)		"George Brown" (Anxiety Neurotic)		"Bobby Grey" (Conduct Disturbance)		"Mary White" (Compulsive-Phobic)		All Examples[a]	
	Serious	Not Serious[b]	Serious	Not Serious	Serious	Not Serious	Serious	Not Serious	Serious	Not Serious	Serious	Not Serious	Serious	Not Serious
Psychiatric	57	37	39	26	20	13	36	25	42	29	[c]	22	41	27
Medical	19	17	19	8	17	8	11	13	6	6		3	16	11
Physical	5	9	3	1	13	4	25	9	-	2		2	7	5
Practical	3	6	3	3	1	3	4	8	19	10		2	4	5
Lay psychological	7	24	27	54	29	37	4	21	34	56		22	20	36
Moral, self-help	14	24	14	17	36	49	32	44	4	6		55	20	29
Total per cent[d]	105	117	105	109	116	114	112	120	105	109		106	108	113
Number	173	293	94	279	124	142	28	179	53	86	2	60	474	1,039

[a]These percentages are based on the total number of examples in the particular classification. They are, therefore, an average of the six preceding examples in which each example is weighted proportionally to the frequency of that category for the example.

[b]This category includes both people who said it was not serious and people who were undecided or did not know.

[c]Too few cases to report percentages.

[d]Totals exceed 100% because a respondent could make more than one recommendation for a single example.

TABLE 49

SUMMARY OF USE OF SELECTED TERMINOLOGY IN DISCUSSING SIX EXAMPLES OF HUMAN BEHAVIOR

Term	Proportion of All Respondents Using Each Term	Proportion of All Users Referring Term to Mental Illness Only	Example Primarily Referred to[a]	Intra-Example Association Between Use of Term and Perception of Mental Illness[b]
DIAGNOSIS				
Schizophrenia .	2	95	"Frank Jones" (85)	+
Psychosis . . .	1	84	"Frank Jones" (58)	+
Neurosis . . .	3	58	"Frank Jones," "George Brown" (40,33)	+
Nervousness . .	26	33	"George Brown" (60)	0
SYMPTOMS				
Hallucination .	1	89	"Frank Jones" (89)	+
Delusion . . .	1	86	"Frank Jones" (79)	+
Persecution complex . . .	4	92	"Frank Jones" (98)	+
Guilt complex .	1	79	"Frank Jones" (82)	+
Inferiority complex . .	21	38	"Betty Smith" (60)	0
Fear complex .	1	34	"Mary White" (59)	?
Complex, general	6	43	"Frank Jones," "Betty Smith" (40,36)	?
Introversion .	4	48	"Betty Smith" (90)	+
Claustrophobia	2	13	"Mary White" (100)	+
Phobia, general	6	19	"Mary White" (88)	?

[a] Where the term was applied to a single example by over 50% of its users, only that example is listed. If no example had this kind of majority association with the term, the two examples to which the term was most frequently applied, which together were what the majority had in mind when they used the term, are listed in order of frequency. The percentage of users applying the term to the example(s) listed is shown in parentheses.

[b] A plus sign indicates that, for each example where the term was used, people who used the term were more likely to call the example mentally-ill than people who did not, while a minus sign indicates the reverse. A zero indicates that use or non-use of the term was not related to the frequency with which an example was perceived to be mentally-ill, while a question-mark is used to indicate that differences were not consistent throughout the examples and/or there were too few cases to determine the direction of the difference.

TABLE 49--Continued

Term	Proportion of All Respondents Using Each Term	Proportion of All Users Referring Term to Mental Illness Only	Example Primarily Referred to[a]	Intra-Example Association Between Use of Term and Perception of Mental Illness[b]
SYMPTOMS--Cont'd.				
Obsession . . .	2	59	"Frank Jones,""Mary White"(43,39)	+
Fixation . . .	*	41	"Mary White,""Frank Jones"(47,35)	?
Compulsion . .	1	41	"Mary White" (68)	?
Quirk	3	27	"Mary White" (58)	+
Superstition .	3	9	"Mary White" (82)	-
Habit	32	1	"Bill Williams" (72)	-
Alcoholism . .	23	40	"Bill Williams" (99)	+
Kleptomania . .	3	45	"Bobby Grey" (98)	+
Mania, general	1	56	"Mary White,""Bobby Grey"(33,25)	+

*Less than 0.5%.

TABLE 50

TYPE AND NUMBER OF SOURCES OF INFORMATION ABOUT MENTAL ILLNESS WITHIN EDUCATIONAL ATTAINMENT GROUPS

Information Source		Proportion of Indicated Educational Attainment Group Mentioning Each Information Source						
		College Graduate and Above	Some College	High School Graduate	Some High School	Grammar School Graduate	Less Than Grammar School Graduate	Total
KIND:	Newspapers	81	79	73	65	57	37	62
	Magazines	88	87	76	63	45	28	60
	Family and friends	76	68	61	57	51	43	56
	Radio	54	53	48	48	40	36	45
	Movies	62	48	50	45	28	19	39
	Books (other than text)	66	53	32	29	20	15	30
	Lectures	62	45	26	22	15	12	25
	Family doctor	32	29	20	20	15	15	20
	Contacts with mentally-ill[a]	13	13	10	11	10	9	11
	General, everyday experience[a]	2	5	4	5	5	4	5
	Social contacts with professionally trained[a]	7	3	3	3	2	2	3
	Own professional training[a]	13	3	2	1	*	*	2
	Non-professional work contacts with professionally trained[a]	1	3	1	2	2	2	2
	General formal education[a]	13	9	1	1	-	-	2
	Television[a]	*	2	1	*	1	1	1
	Miscellaneous[a]	1	1	1	*	*	*	*
	Total per cent[b]	571	501	409	372	291	223	363

*Less than 0.5%.

[a]Information sources were, in general, reported in answer to a series of questions which asked specifically about each source; e.g., "Have you ever read anything in the newspapers about mental health problems?"; "Have you ever read any magazine articles about mental health problems?"; etc. The last eight categories shown above under kinds of information sources were not, however, specifically inquired about, but were volunteered in answer to the final, general question in the information series: "Have you ever seen or heard anything else about mental health problems?".

[b]Totals exceed 100% because most respondents named more than one kind or type of source.

TABLE 50--Continued

Information Source	Proportion of Indicated Educational Attainment Group Mentioning Each Information Source						
	College Graduate and Above	Some College	High School Graduate	Some High School	Grammar School Graduate	Less Than Grammar School Graduate	Total
TYPE:[c]							
All Mentions							
Class media	78	65	46	40	27	22	40
Mass media	95	95	92	87	75	59	81
Interpersonal communication	81	75	69	66	60	53	65
Total per cent[b] . .	254	235	207	193	162	134	186
"Best" Mention							
Class media included . .	78	65	46	40	27	22	40
Mass media, but no class media	19	30	48	48	50	39	43
Interpersonal communication only	2	3	3	7	12	16	8
No sources	1	2	3	5	11	23	9
Total per cent . .	100	100	100	100	100	100	100
NUMBER: None	1	2	3	5	11	23	9
One	4	4	7	11	19	22	13
Two	6	6	15	16	20	18	15
Three	9	15	15	18	14	14	15
Four	10	14	17	16	14	9	14
Five	10	19	16	13	9	7	12
Six	22	13	13	9	7	4	10
Seven	18	15	9	7	4	2	7
Eight	11	8	4	4	2	1	4
Nine or more	9	4	1	1	*	*	1
Total per cent . .	100	100	100	100	100	100	100
Number	246	360	786	768	675	696	3,531

[c]"Mass media" include newspapers, magazines, radio, movies and television; "class media" include books, lectures, professional training and formal education; "interpersonal communication" includes talking with family and friends or with family doctors, work or social contacts with professionally trained persons, acquaintance with mentally-ill persons and general, everyday experience.

TABLE 51

RELATION OF INFORMATION EXPOSURE TO CONCEPTIONS OF MENTAL ILLNESS

Conception of Mental Illness	Proportion of Each Information Exposure Group with Indicated Conception of Mental Illness		
	High Exposure (6 or More Sources)	Middle Exposure (3-5 Sources)	Low Exposure (0-2 Sources)
GENERAL CONCEPTIONS			
First impression spontaneously included non-psychotic syndromes	54	48	36
Mental illness included more than "insanity"	90	84	74
"Nervous breakdown" was mental illness	59	48	39
Total Usage: Consistent non-psychotic	37	30	21
Inconsistent non-psychotic	50	47	45
Inconsistent psychotic	11	16	17
Consistent psychotic	2	6	11
No impression	*	1	6
Total per cent	100	100	100
CONCRETE PERCEPTIONS (Proportion classifying examples as mentally-ill)			
"Frank Jones" (Paranoid)	85	77	68
"Betty Smith" (Simple Schizophrenic)	45	33	28
"Bill Williams" (Alcoholic)	44	29	18
"George Brown" (Anxiety Neurotic)	25	17	14
"Bobby Grey" (Conduct Disturbance)	21	14	10
"Mary White" (Compulsive-Phobic)	13	6	5
At least one of above	92	85	76
Four-question summary:			
Personality disorder (and all others below) included	7	3	2
Neurosis (and all others below) included	11	7	7
Limited to psychosis, generally	21	20	14
Limited to violent psychosis	36	40	39
No apparent recognition	12	19	28
Usage not consistently classifiable	13	11	10
Total per cent	100	100	100
LOGICAL CRITERIA			
Descriptive: Emotional-functional deviancy	61	48	37
Cognitive-control deviancy	22	28	31
General deviancy	17	24	32
Total per cent	100	100	100
Non-descriptive: Organic disease	22	22	17
Non-physical disorder	34	33	30
Counter-reality, inexplicable behavior	66	62	56
Volitional defect	40	40	32
Involuntary action	26	26	30
Descriptive only	9	11	16
Total per cent[a]	197	194	181
Logical consistency: Contradicted own criteria	86	82	78
Number of cases	798	1,449	1,284

*Less than 0.5%.

[a]Totals exceed 100% because respondents often employed more than one criterion.

TABLE 52

EDUCATIONAL DIFFERENCES IN CONCEPTIONS OF MENTAL ILLNESS

Conception of Mental Illness	Proportion of Each Educational Attainment Group with Indicated Conceptions of Mental Illness					
	College Graduate and Above	Some College	High School Graduate	Some High School	Grammar School Graduate	Less Than Grammar School Graduate
GENERAL CONCEPTIONS						
First impression spontaneously included non-psychotic syndromes	64	58	47	44	41	34
Mental illness included more than "insanity"	92	91	88	84	79	71
"Nervous breakdown" was mental illness	63	61	53	45	42	38
Total Usage: Consistent non-psychotic	44	38	33	26	22	20
Inconsistent non-psychotic	44	47	46	50	47	42
Inconsistent psychotic	9	13	15	15	17	17
Consistent psychotic	2	2	5	7	8	14
No impression	1	*	1	2	6	7
Total per cent	100	100	100	100	100	100
CONCRETE PERCEPTIONS (Proportion classifying examples as mentally-ill)						
"Frank Jones" (Paranoid)	87	84	80	73	71	68
"Betty Smith" (Simple Schizophrenic)	53	45	34	31	30	28
"Bill Williams" (Alcoholic)	52	44	33	26	20	18
"George Brown" (Anxiety Neurotic)	31	24	16	16	18	16
"Bobby Grey" (Conduct Disturbance)	27	20	16	12	9	11
"Mary White" (Compulsive-Phobic)	15	12	6	4	6	7
At least one of above	95	90	88	82	78	76
Four-question summary: Personality disorder (and all others below) included	9	8	3	2	2	3
Neurosis (and all others below) included	15	10	8	6	9	7
Limited to psychosis, generally	22	23	20	18	16	12
Limited to violent psychosis	31	35	44	39	37	39
No apparent recognition	8	13	16	23	25	27
Usage not consistently classifiable	15	11	9	12	11	12
Total per cent	100	100	100	100	100	100
LOGICAL CRITERIA						
Descriptive: Emotional-functional deviancy	68	60	51	45	43	34
Cognitive-control deviancy	18	19	26	31	26	37
General deviancy	14	21	23	24	31	29
Total per cent	100	100	100	100	100	100
Non-descriptive: Organic disease	20	25	20	21	18	18
Non-physical disorder	30	29	33	34	29	29
Counter-reality, inexplicable behavior	65	65	66	63	61	52
Volitional defect	44	43	41	37	37	27
Involuntary action	23	30	27	26	29	28
Descriptive only	11	8	10	12	12	19
Total per cent[a]	193	200	197	193	186	173
Logical consistency: Contradicted own criteria	84	87	84	82	79	68
Number of cases	246	360	786	768	675	696

*Less than 0.5%.

[a]Totals exceed 100% because respondents often employed more than one criterion.

TABLE 53

RELATION OF EDUCATION AND INFORMATION EXPOSURE TO CONCEPTIONS OF MENTAL ILLNESS

Conception of Mental Illness and Educational Level	Proportion of Indicated Information Exposure Group at Each Educational Level with Stated Conception of Mental Illness		
	High Exposure (6 or More Sources)	Middle Exposure (3-5 Sources)	Low Exposure (0-2 Sources)
GENERAL CONCEPTIONS			
First impression spontaneously included non-psychotic syndromes			
College graduate and above	63 (148)[a]	48 (72)	51 (26)
Some college	59 (145)	57 (173)	38 (42)
High school graduate	51 (205)	48 (384)	39 (197)
Some high school	52 (157)	46 (364)	37 (247)
Grammar school graduate	44 (89)	46 (250)	40 (336)
Less than grammar school graduate	40 (54)	45 (206)	31 (436)
Mental illness included more than "insanity"			
College graduate and above	97	86	50
Some college	93	90	93
High school graduate	90	89	87
Some high school	88	85	80
Grammar school graduate	81	83	75
Less than grammar school graduate	87	80	62
"Nervous breakdown" was mental illness			
College graduate and above	66	60	31
Some college	67	60	43
High school graduate	56	54	47
Some high school	52	46	38
Grammar school graduate	52	44	38
Less than grammar school graduate	57	42	35
Total usage sometimes included description of non-psychotic syndromes			
College graduate and above	89	82	82
Some college	87	83	74
High school graduate	85	78	76
Some high school	82	76	73
Grammar school graduate	75	75	65
Less than grammar school graduate	82	71	58
Total usage consistently included non-psychotic syndromes			
College graduate and above	48	38	38
Some college	43	36	31
High school graduate	37	34	28
Some high school	31	27	22
Grammar school graduate	26	24	20
Less than grammar school graduate	26	25	17
CONCRETE PERCEPTIONS			
"Frank Jones" (Paranoid) was mentally-ill			
College graduate and above	90	82	85
Some college	86	84	79
High school graduate	88	81	72
Some high school	82	73	67
Grammar school graduate	78	75	68
Less than grammar school graduate	67	74	63
"Betty Smith" (Simple Schizophrenic) was mentally-ill			
College graduate and above	59	49	27
Some college	52	41	36
High school graduate	46	32	26
Some high school	38	31	27
Grammar school graduate	30	29	31
Less than grammar school graduate	28	31	26

[a]The figure in parentheses is the number of cases on which this percentage (and all others in the table for the same sub-group) is based.

TABLE 53--Continued

Conception of Mental Illness and Educational Level	Proportion of Indicated Information Exposure Group at Each Educational Level with Stated Conception of Mental Illness		
	High Exposure (6 or More Sources)	Middle Exposure (3-5 Sources)	Low Exposure (0-2 Sources)
CONCRETE CONCEPTIONS--Continued			
"Bill Williams" (Alcoholic) was mentally-ill			
College graduate and above	61	40	38
Some college	52	41	29
High school graduate	44	29	26
Some high school	38	27	17
Grammar school graduate	28	25	14
Less than grammar school graduate	22	25	15
"George Brown" (Anxiety Neurotic) was mentally-ill			
College graduate and above	35	28	19
Some college	28	23	12
High school graduate	22	14	12
Some high school	22	16	11
Grammar school graduate	20	20	16
Less than grammar school graduate	18	16	16
"Bobby Grey" (Conduct Disturbance) was mentally-ill			
College graduate and above	34	18	12
Some college	20	22	12
High school graduate	22	16	12
Some high school	17	12	9
Grammar school graduate	11	9	9
Less than grammar school graduate	6	14	8
"Mary White" (Compulsive-phobic) was mentally-ill			
College graduate and above	20	8	4
Some college	17	10	5
High school graduate	8	5	4
Some high school	8	4	2
Grammar school graduate	10	7	4
Less than grammar school graduate	17	4	6
At least one of above was mentally-ill			
College graduate and above	96	94	92
Some college	94	90	86
High school graduate	92	88	83
Some high school	90	81	78
Grammar school graduate	87	83	72
Less than grammar school graduate	83	83	72
Concrete perceptions consistently extended at least through neurosis			
College graduate and above	30	17	12
Some college	24	15	10
High school graduate	19	8	7
Some high school	11	8	6
Grammar school graduate	11	10	12
Less than grammar school graduate	7	10	10

TABLE 53--Continued

Conception of Mental Illness and Educational Level	Proportion of Indicated Information Exposure Group at Each Educational Level with Stated Conception of Mental Illness		
	High Exposure (6 or More Sources)	Middle Exposure (3-5 Sources)	Low Exposure (0-2 Sources)
LOGICAL CRITERIA			
Descriptively defined mental illness as emotional-functional deviancy			
College graduate and above	72	64	50
Some college	65	58	48
High school graduate	60	52	44
Some high school	52	45	40
Grammar school graduate	61	46	38
Less than grammar school graduate	55	38	30
Used any non-descriptive criteria			
College graduate and above	89	92	81
Some college	89	94	91
High school graduate	94	89	89
Some high school	90	89	87
Grammar school graduate	89	90	87
Less than grammar school graduate	98	83	78
Used criterion of organic disease			
College graduate and above	17	26	15
Some college	26	28	14
High school graduate	23	21	16
Some high school	21	20	22
Grammar school graduate	21	21	17
Less than grammar school graduate	22	19	16
Used criterion of non-physical disorder			
College graduate and above	35	28	23
Some college	32	28	26
High school graduate	39	32	34
Some high school	28	40	36
Grammar school graduate	31	28	29
Less than grammar school graduate	39	33	26
Used criterion of counter-reality, inexplicable behavior			
College graduate and above	62	72	62
Some college	62	65	69
High school graduate	68	65	65
Some high school	71	62	59
Grammar school graduate	69	59	60
Less than grammar school graduate	61	59	47
Used criterion of volitional defect			
College graduate and above	40	50	50
Some college	43	44	38
High school graduate	39	40	45
Some high school	38	39	32
Grammar school graduate	40	38	36
Less than grammar school graduate	37	34	23
Used criterion of involuntary action			
College graduate and above	20	31	19
Some college	36	26	29
High School graduate	25	29	27
Some high school	24	25	27
Grammar school graduate	29	24	34
Less than grammar school graduate	26	27	30
Contradicted own criteria of mental illness			
College graduate and above	84	86	81
Some college	85	87	86
High school graduate	88	83	80
Some high school	85	82	80
Grammar school graduate	88	81	75
Less than grammar school graduate	85	74	64

TABLE 62--Continued

E.: Occupational Differences

Conception of Mental Illness	Proportion of Each Occupational Group with Indicated Conception of Mental Illness[b]							
	Profes-sional	Mana-gerial	Cler-ical	Serv-ice	Skilled	Semi-Skilled	Un-Skilled	Farm-er
GENERAL CONCEPTIONS								
First impression spontaneously included non-psychotic syndromes	57	50	52	44	42	41	36	37
Mental illness included more than "insanity"	87	89	87	74	86	80	72	69
"Nervous breakdown" was mental illness	60	61	52	45	49	47	41	43
Total Usage: Consistent non-psychotic	40	41	36	23	31	25	20	22
Inconsistent non-psychotic	45	42	49	47	41	46	47	45
Inconsistent psychotic	11	10	10	16	17	20	16	16
Consistent psychotic	3	6	4	10	7	8	13	12
No impression	1	1	1	4	4	1	4	5
Total per cent	100	100	100	100	100	100	100	100
CONCRETE PERCEPTIONS (Proportion classifying examples as mentally-ill)								
"Frank Jones" (Paranoid)	83	88	81	76	72	70	69	72
"Betty Smith" (Simple Schizophrenic)	47	40	35	37	32	27	32	26
"Bill Williams" (Alcoholic)	46	41	36	30	25	23	20	17
"George Brown" (Anxiety Neurotic)	32	22	20	20	17	15	19	17
"Bobby Grey" (Conduct Disturbance)	24	20	17	9	13	10	11	11
"Mary White" (Compulsive-Phobic)	11	8	8	10	8	5	8	6
At least one of above	91	93	88	85	82	79	79	78
Four-question summary:								
Personality disorder (and all others below) included	7	6	4	3	3	2	5	2
Neurosis (and all others below) included	16	12	8	11	7	5	8	8
Limited to psychosis, generally.	16	22	20	18	16	17	14	13
Limited to violent psychosis	33	43	41	36	38	37	36	41
No apparent recognition	12	11	15	20	23	26	26	25
Usage not consistently classifiable	16	6	12	12	13	13	11	11
Total per cent	100	100	100	100	100	100	100	100
LOGICAL CRITERIA								
Descriptive: Emotional-functional deviancy	65	58	50	49	45	43	37	35
Cognitive-control deviancy	18	26	29	29	31	30	35	33
General deviancy	17	16	21	22	24	27	28	32
Total per cent	100	100	100	100	100	100	100	100
Non-descriptive: Organic disease	22	22	20	19	17	21	20	23
Non-physical disorder	33	33	31	32	34	29	27	34
Counter-reality, inexplicable behavior	65	67	65	57	65	59	53	59
Volitional defect	40	45	47	34	42	31	29	36
Involuntary action	23	29	30	26	33	26	28	32
Descriptive only	12	10	10	16	8	16	15	11
Total per cent[a]	195	206	203	184	199	182	172	195
Logical consistency: Contradicted own criteria	87	85	84	78	82	73	74	77
Number of cases	234	213	312	176	342	331	220	242

[b] The "not-gainfully employed" group, consisting largely of housewives, the retired and students, is omitted for simplicity.

TABLE 62--Continued

F.: Economic Differences

Conception of Mental Illness	Proportion of Each Annual Family Income Group with Indicated Conception of Mental Illness[c]							
	$10,000 and Over	$7,500 to $9,999	$5,000 to $7,499	$4,000 to $4,999	$3,000 to $3,999	$2,000 to $2,999	$1,000 to $1,999	Under $1,000
GENERAL CONCEPTIONS								
First impression spontaneously included non-psychotic syndromes	59	55	57	51	47	44	39	35
Mental illness included more than "insanity"	94	95	90	87	88	82	78	68
"Nervous breakdown" was mental illness	61	56	60	51	50	46	41	43
Total Usage: Consistent non-psychotic	43	45	40	33	30	26	23	22
Inconsistent non-psychotic	39	37	44	46	49	49	50	40
Inconsistent psychotic	13	13	12	12	15	17	17	16
Consistent psychotic	4	2	3	6	3	6	5	17
No impression	1	3	1	3	3	2	5	5
Total per cent	100	100	100	100	100	100	100	100
CONCRETE PERCEPTIONS (Proportion classifying examples as mentally-ill)								
"Frank Jones" (Paranoid)	90	86	83	78	77	74	71	71
"Betty Smith" (Simple Schizophrenic)	48	46	41	35	34	32	30	36
"Bill Williams" (Alcoholic)	44	43	43	34	31	25	23	21
"George Brown" (Anxiety Neurotic)	18	23	20	22	17	15	19	22
"Bobby Grey" (Conduct Disturbance)	22	25	21	20	14	11	11	13
"Mary White" (Compulsive-Phobic)	8	18	8	9	6	5	8	7
At least one of above	96	91	91	88	85	81	79	79
Four-question summary:								
Personality disorder (and all others below) included	4	13	5	5	3	2	3	4
Neurosis (and all others below) included	10	6	10	9	9	7	7	10
Limited to psychosis, generally	29	23	23	15	18	18	15	18
Limited to violent psychosis	39	38	39	40	40	41	37	33
No apparent recognition	8	12	14	17	20	22	23	24
Usage not consistently classifiable	10	8	9	14	10	10	15	11
Total per cent	100	100	100	100	100	100	100	100
LOGICAL CRITERIA								
Descriptive: Emotional-functional deviancy	58	54	57	55	53	42	42	40
Cognitive-control deviancy	21	18	25	26	23	31	31	32
General deviancy	21	28	18	19	24	27	27	28
Total per cent	100	100	100	100	100	100	100	100
Non-descriptive: Organic disease	14	16	25	20	19	21	20	20
Non-physical disorder	34	32	39	32	34	31	30	30
Counter-reality, inexplicable behavior	69	64	64	63	63	63	55	58
Volitional defect	42	39	42	42	38	38	31	34
Involuntary action	26	18	24	26	27	27	27	34
Descriptive only	10	15	8	12	10	11	18	13
Total per cent[a]	195	184	202	195	191	191	181	189
Logical consistency: Contradicted own criteria	86	84	83	83	85	81	73	71
Number of cases	77	85	253	392	763	870	538	427

[c]Omits those respondents who did not report their family income.

TABLE 62--Continued

G.: Regional Differences

Conception of Mental Illness	Proportion of Residents of Each Region with Indicated Conception of Mental Illness[d]			
	East	Middle West	West	South
GENERAL CONCEPTIONS				
First impression spontaneously included non-psychotic syndromes	44	44	48	46
Mental illness included more than "insanity"	87	79	90	77
"Nervous breakdown" was mental illness	58	45	54	47
Total Usage: Consistent non-psychotic	30	25	34	27
Inconsistent non-psychotic	50	48	40	44
Inconsistent psychotic	14	15	20	15
Consistent psychotic	4	7	4	10
No impression	2	5	2	4
Total per cent	100	100	100	100
CONCRETE PERCEPTIONS (Proportion classifying examples as mentally-ill)				
"Frank Jones" (Paranoid)	74	73	83	77
"Betty Smith" (Simple Schizophrenic)	32	31	40	36
"Bill Williams" (Alcoholic)	29	25	36	28
"George Brown" (Anxiety Neurotic)	16	16	20	21
"Bobby Grey" (Conduct Disturbance)	12	13	17	16
"Mary White" (Compulsive-Phobic)	6	6	8	8
At least one of above	81	82	88	85
Four-question summary:				
Personality disorder (and all others below) included	3	3	5	4
Neurosis (and all others below) included	8	7	9	10
Limited to psychosis, generally	16	17	22	18
Limited to violent psychosis	40	40	39	37
No apparent recognition	23	23	14	18
Usage not consistently classifiable	10	10	11	13
Total per cent	100	100	100	100
LOGICAL CRITERIA				
Descriptive: Emotional-functional deviancy	48	42	55	48
Cognitive-control deviancy	27	28	25	30
General deviancy	25	30	20	22
Total per cent	100	100	100	100
Non-descriptive: Organic disease	18	20	20	23
Non-physical disorder	29	32	34	32
Counter-reality, inexplicable behavior	62	63	66	57
Volitional defect	34	41	41	35
Involuntary action	26	31	24	27
Descriptive only	14	11	11	13
Total per cent[a]	183	198	196	187
Logical consistency: Contradicted own criteria	81	80	83	77
Number of cases	1,001	1,057	437	1,036

[d]The regional subdivisions used here are:

East: New England and Middle Atlantic States
Middle West: East North Central and West North Central States
West: Mountain and Pacific States
South: South Atlantic, East South Central and West South Central States

TABLE 62--Continued

H.: Rural-Urban Differences

Conception of Mental Illness	Proportion of Residents of Each City Size with Indicated Conception of Mental Illness				
	Metropolitan Center	City	Town	Village	Farm
GENERAL CONCEPTIONS					
First impression spontaneously included non-psychotic syndromes	46	47	44	47	41
Mental illness included more than "insanity"	87	81	84	82	75
"Nervous breakdown" was mental illness	48	48	47	50	44
Total Usage: Consistent non-psychotic	30	29	29	31	25
Inconsistent non-psychotic	49	48	44	44	44
Inconsistent psychotic	14	15	16	15	17
Consistent psychotic	4	5	7	9	11
No impression	3	3	4	1	3
Total per cent	100	100	100	100	100
CONCRETE PERCEPTIONS (Proportion classifying examples as mentally-ill)					
"Frank Jones" (Paranoid)	76	74	77	79	72
"Betty Smith" (Simple Schizophrenic)	35	32	37	35	32
"Bill Williams" (Alcoholic)	32	30	28	27	21
"George Brown" (Anxiety Neurotic)	16	17	18	24	17
"Bobby Grey" (Conduct Disturbance)	14	15	13	13	15
"Mary White" (Compulsive-Phobic)	8	6	7	8	6
At least one of above	83	83	86	85	79
Four-question summary:					
Personality disorder (and all others below) included	3	3	4	4	3
Neurosis (and all others below) included	8	7	8	12	7
Limited to psychosis, generally	19	17	20	15	19
Limited to violent psychosis	39	40	39	40	36
No apparent recognition	21	21	18	17	24
Usage not consistently classifiable	10	12	11	12	11
Total per cent	100	100	100	100	100
LOGICAL CRITERIA					
Descriptive: Emotional-functional deviancy	53	46	48	50	36
Cognitive-control deviancy	25	30	27	27	30
General deviancy	22	24	25	23	34
Total per cent	100	100	100	100	100
Non-descriptive: Organic disease	16	21	24	23	21
Non-physical disorder	31	36	30	29	30
Counter-reality, inexplicable behavior	62	65	58	60	59
Volitional defect	35	42	37	40	32
Involuntary action	24	28	29	29	30
Descriptive only	14	12	11	12	13
Total per cent[a]	182	204	189	193	185
Logical consistency: Contradicted own criteria	79	80	81	81	78
Number of cases	972	892	553	537	577

TABLE 54

RELATION OF EDUCATION, INFORMATION EXPOSURE AND GENERAL CONCEPTIONS TO CONCEPTIONS OF MENTAL ILLNESS

Conception and Educational Level	Proportion of Indicated Information Exposure and Usage Group at Each Educational Level with Stated Conception of Mental Illness					
	General Usage Consistently Included Non-Psychotic Syndromes			General Usage Did Not Consistently Include Non-Psychotic Syndromes		
	High Exposure (6 or More Sources)	Middle Exposure (3-5 Sources)	Low Exposure (0-2 Sources)	High Exposure (6 or More Sources)	Middle Exposure (3-5 Sources)	Low Exposure (0-2 Sources)
CONCRETE PERCEPTIONS						
"Frank Jones" (Paranoid) was mentally-ill						
Any college	92 (133)[a]	93 (90)	89 (23)	86 (160)	76 (155)	56 (45)
High school graduate	93 (75)	86 (132)	77 (56)	84 (130)	78 (252)	70 (141)
Some high school	91 (49)	77 (97)	71 (55)	76 (108)	70 (267)	67 (192)
Less than high school	75 (37)	82 (112)	77 (139)	73 (106)	71 (344)	63 (633)
"Betty Smith" (Simple Schizophrenic) was mentally-ill						
Any college	69	54	48	38	35	22
High school graduate	56	41	35	39	26	22
Some high school	39	33	26	37	30	27
Less than high school	34	33	33	27	29	27
"Bill Williams" (Alcoholic) was mentally-ill						
Any college	67	44	44	44	38	24
High school graduate	56	41	36	36	22	21
Some high school	47	36	26	33	23	14
Less than high school	39	30	18	20	23	13
"George Brown" (Anxiety Neurotic) was mentally-ill						
Any college	41	34	26	21	17	7
High school graduate	32	23	21	15	8	8
Some high school	33	23	15	16	12	10
Less than high school	20	24	24	19	16	14

[a]The figure in parentheses is the number of cases on which this percentage (and all others in the table for the same sub-group) is based.

TABLE 54--Continued

Conception and Educational Level	Proportion of Indicated Information Exposure and Usage Group at Each Educational Level with Stated Conception of Mental Illness					
	General Usage Consistently Included Non-Psychotic Syndromes			General Usage Did Not Consistently Include Non-Psychotic Syndromes		
	High Exposure (6 or More Sources)	Middle Exposure (3-5 Sources)	Low Exposure (0-2 Sources)	High Exposure (6 or More Sources)	Middle Exposure (3-5 Sources)	Low Exposure (0-2 Sources)
CONCRETE PERCEPTIONS--Continued						
"Bobby Grey" (Conduct Disturbance) was mentally-ill						
Any college	33	27	15	20	16	10
High school graduate	23	19	12	21	13	11
Some high school	18	18	8	17	9	10
Less than high school	11	17	12	8	9	8
"Mary White" (Compulsive-Phobic) was mentally-ill						
Any college	24	12	4	11	7	5
High school graduate	11	8	11	5	4	1
Some high school	9	3	-	7	4	3
Less than high school	14	7	8	13	5	5
At least one of above was mentally-ill						
Any college	99	97	93	90	87	85
High school graduate	98	92	91	88	84	79
Some high school	96	84	83	87	79	76
Less than high school	89	88	80	84	81	72
Consistently extended perceptions at least through neurosis						
Any college	36	23	19	17	9	5
High school graduate	25	12	12	15	6	4
Some high school	16	11	6	9	7	6
Less than high school	9	12	18	10	9	9

TABLE 54--Continued

Conception and Educational Level	Proportion of Indicated Information Exposure and Usage Group at Each Educational Level with Stated Conception of Mental Illness					
	General Usage Consistently Included Non-Psychotic Syndromes			General Usage Did Not Consistently Include Non-Psychotic Syndromes		
	High Exposure (6 or More Sources)	Middle Exposure (3-5 Sources)	Low Exposure (0-2 Sources)	High Exposure (6 or More Sources)	Middle Exposure (3-5 Sources)	Low Exposure (0-2 Sources)
LOGICAL CRITERIA						
Descriptively defined mental illness as emotional-functional deviancy						
Any college	74	73	63	62	49	39
High school graduate	69	60	56	52	46	37
Some high school	58	50	39	48	43	41
Less than high school	73	49	46	53	40	30
Used any non-descriptive criteria						
Any college	85	97	85	93	91	88
High school graduate	92	91	91	95	88	88
Some high school	95	90	91	87	89	85
Less than high school	96	92	87	91	85	81
Used criterion of organic disease						
Any college	25	32	15	16	24	15
High school graduate	26	28	24	21	17	12
Some high school	33	25	25	14	18	21
Less than high school	27	28	21	19	17	15
Used criterion of non-physical disorder						
Any college	18	21	26	40	33	24
High school graduate	35	30	29	41	32	37
Some high school	25	32	45	30	43	32
Less than high school	32	26	27	35	33	30

TABLE 54--Continued

Conception and Educational Level	Proportion of Indicated Information Exposure and Usage Group at Each Educational Level with Stated Conception of Mental Illness					
	General Usage Consistently Included Non-Psychotic Syndromes			General Usage Did Not Consistently Include Non-Psychotic Syndromes		
	High Exposure (6 or More Sources)	Middle Exposure (3-5 Sources)	Low Exposure (0-2 Sources)	High Exposure (6 or More Sources)	Middle Exposure (3-5 Sources)	Low Exposure (0-2 Sources)
LOGICAL CRITERIA--Continued						
Used criterion of counter-reality, inexplicable behavior						
Any college	65	76	78	58	61	59
High school graduate	78	72	71	60	60	62
Some high school	81	73	71	66	57	55
Less than high school	66	73	63	66	53	50
Used criterion of volitional defect						
Any college	36	47	59	48	46	32
High school graduate	40	44	50	38	38	43
Some high school	40	45	34	37	37	31
Less than high school	43	42	33	37	34	27
Used criterion of involuntary action						
Any college	24	23	19	33	30	29
High school graduate	19	28	26	29	29	28
Some high school	19	22	25	27	27	28
Less than high school	25	27	30	29	25	32
Contradicted own criteria of mental illness						
Any college	81	87	85	88	87	83
High school graduate	81	83	76	93	83	82
Some high school	86	82	74	85	82	82
Less than high school	86	80	74	87	77	67

TABLE 55

CONTACT WITH TREATED CASES OF MENTAL ILLNESS, WITHIN EDUCATIONAL ATTAINMENT GROUPS[a]

Degree of Contact	Proportion of Indicated Educational Attainment Group Reporting Each Degree of Contact with Treated Patients						
	College Graduate and Above	Some College	High School Graduate	Some High School	Grammar School Graduate	Less Than Grammar School Graduate	Total
None reported	14	18	20	22	26	25	22
Institutionalized patients only	35	46	53	55	59	64	55
Institutionalized and extra-mural patients	43	30	22	19	12	9	19
Extra-mural patients only	8	6	5	4	3	2	4
Total per cent	100	100	100	100	100	100	100
Number	246	360	786	768	675	696	3,531
Institutionalized patient was:							
Self	-	1	*	*	*	1	*
Immediate family[b]	4	5	4	8	5	8	6
Other relatives	14	12	12	14	14	16	14
Close friends	21	24	23	22	22	21	22
Acquaintances	48	45	43	39	36	37	40
Other and unclassifiable	5	1	2	3	3	2	2
Total per cent knowing institutionalized patient[c]	78	76	75	74	71	73	74
Extra-mural patient was:							
Self	2	3	2	1	1	1	2
Immediate family[b]	3	3	3	3	2	1	2
Other relatives	4	4	3	2	1	2	3
Close friends	20	13	8	7	3	3	7
Acquaintances	23	16	12	9	7	4	10
Other and unclassifiable	3	1	1	1	1	*	1
Total per cent knowing extra-mural patient[c]	51	36	27	23	15	11	23

*Less than 0.5 per cent.

[a]Based on the questions, "Did you ever know anyone who was in a hospital (asylum) because of a mental illness?" and "Did you ever know anyone (other than persons mentioned in /preceding question/) who was seeing a psychiatrist without being in a mental hospital (asylum), or going to a guidance or mental hygiene clinic?". In each instance, those who said "Yes" were asked further, "Was this a relative, a close friend, or just someone you didn't know very well?".

[b]Includes only parents, siblings, spouse and offspring.

[c]These totals are sometimes smaller than the sum of the sub-categories which precede them, because a respondent could know patients in more than one category.

TABLE 56

EDUCATION, INFORMATION AND EXPERIENCE AS FACTORS IN CAUSAL EXPLANATIONS OF HUMAN BEHAVIOR

Cause	Educational Attainment						Information Exposure			Contact with Psychiatric Patients			Summary[a]		
	College Graduate and Above	Some College	High School Graduate	Some High School	Grammar School Graduate	Less Than Grammar School Graduate	High Exposure (6 or More Sources)	Middle Exposure (3-5 Sources)	Low Exposure (0-2 Sources)	Non-Institutionalized Patients	Institutionalized Patients Only	None Reported	Highest Involvement	Intermediate Involvement	Lowest Involvement
Proportion of ALL RESPONDENTS in group															
Organic processes directly affecting brain, nervous system	36	29	31	40	42	47	38	38	40	38	41	32	30	39	35
Diffuse physical processes.	20	25	26	27	30	29	27	27	28	25	30	22	17	28	19
Innate personality, will, choice .	35	42	40	44	44	47	42	45	42	40	45	39	41	44	33
External environment, circumstances	78	81	78	78	74	67	78	79	69	80	73	74	80	75	70
Direct, equivalent conditioning . .	89	90	91	90	87	82	90	91	83	89	88	84	88	88	77
Other psychodynamic relationships .	77	79	69	58	49	40	72	62	46	71	55	55	84	59	40
No causal explanation	1	*	1	1	1	3	*	1	2	1	1	2	1	1	4
Total per cent[b]	336	346	336	338	327	315	347	343	310	344	333	308	341	334	278
Number of respondents	246	360	786	768	675	696	798	1,449	1,284	815	1,931	785	160	3,131	240

*Less than 0.5%.

[a]The group with highest involvement is defined as those with contacts with non-institutionalized patients, high information exposure, and at least some college education. The group with lowest involvement are those with no reported contacts with the mentally-ill, low information exposure and no high school education. All other combinations of contact, information exposure and educational background are classified as intermediate.

[b]Totals exceed 100% because most respondents used more than one causal explanation in the course of discussing the six examples.

TABLE 56--Continued

Cause	Educational Attainment						Information Exposure			Contact with Psychiatric Patients			Summary[a]		
	College Graduate and Above	Some College	High School Graduate	Some High School	Grammar School Graduate	Less Than Grammar School Graduate	High Exposure (6 or More Sources)	Middle Exposure (3-5 Sources)	Low Exposure (0-2 Sources)	Non-Institutionalized Patients	Institutionalized Patients Only	None Reported	Highest Involvement	Intermediate Involvement	Lowest Involvement
Proportion of ALL EXAMPLES discussed by respondents in group															
Organic processes directly affecting brain, nervous system . . .	8	6	7	9	10	11	9	9	9	8	10	7	6	9	7
Diffuse physical processes . . .	4	5	5	5	7	6	5	6	6	5	6	5	3	6	4
Innate personality, will, choice	8	10	9	10	10	11	9	10	10	10	10	8	10	10	8
External environment, circumstances	24	24	25	23	22	19	25	24	20	25	22	21	27	23	20
Direct, equivalent conditioning .	34	33	38	37	33	29	37	35	31	35	34	33	32	34	29
Other psychodynamic relationships	25	24	20	15	11	9	22	17	11	22	14	14	31	16	8
No causal explanation	25	24	24	26	30	35	23	25	33	24	28	32	22	27	37
Total per cent[c]	128	126	128	125	123	120	130	126	120	129	124	120	131	125	113
Number of examples discussed .	1,476	2,160	4,716	4,608	4,050	4,176	4,788	8,694	7,704	4,890	11,586	4,710	960	18,786	1,440

[c] Totals exceed 100% because some respondents used more than one causal explanation in the course of discussing a single example.

TABLE 56--Continued

Cause	Educational Attainment						Information Exposure			Contact with Psychiatric Patients			Summary[a]		
	College Graduate and Above	Some College	High School Graduate	Some High School	Grammar School Graduate	Less Than Grammar School Graduate	High Exposure (6 or More Sources)	Middle Exposure (3-5 Sources)	Low Exposure (0-2 Sources)	Non-Institutionalized Patients	Institutionalized Patients Only	None Recorded	Highest Involvement	Intermediate Involvement	Lowest Involvement
Proportion of EXAMPLES CAUSALLY EXPLAINED by respondents in group															
Organic processes directly affecting brain, nervous system . .	11	8	9	12	14	17	11	11	13	11	13	10	8	12	12
Diffuse physical processes . .	6	7	7	7	9	10	7	7	9	7	9	7	4	8	7
Innate personality, will, choice	11	13	12	13	15	16	12	13	15	13	15	12	12	14	13
External environment, circumstances	32	32	33	31	31	30	32	32	30	33	31	32	34	31	32
Direct, equivalent conditioning	46	43	49	50	47	45	48	47	46	46	48	48	41	48	46
Other psychodynamic relationships	34	32	26	21	16	14	29	21	16	29	20	20	40	22	16
Total per cent[c]	140	135	136	134	132	132	139	131	129	139	136	129	139	135	126
Number of examples causally explained	1,106	1,648	3,583	3,410	2,838	2,721	13,675	6,494	5,137	3,716	8,373	3,217	753	13,651	902

TABLE 57

EDUCATION, INFORMATION AND EXPERIENCE AS FACTORS IN PROPOSED CORRECTIVE SOLUTIONS OF HUMAN BEHAVIOR

Action Suggested	Proportion of Respondents in Indicated Group Making Each Action Suggestion, Among Respondents Making Any Action Suggestion														
	Educational Attainment						Information Exposure			Contact with Psychiatric Patients			Summary[a]		
	College Graduate and Above	Some College	High School Graduate	Some High School	Grammar School Graduate	Less Than Grammar School Graduate	High Exposure (6 or More Sources)	Middle Exposure (3-5 Sources)	Low Exposure (0-2 Sources)	Non-Institutionalized Patients	Institutionalized Patients Only	None Reported	Highest Involvement	Intermediate Involvement	Lowest Involvement
For any example															
Psychiatric	30	24	19	15	8	7	25	16	8	23	11	14	35	15	4
Medical	7	6	9	10	9	8	9	9	8	7	8	10	7	8	8
Physical	29	21	21	24	25	24	23	23	23	23	25	19	20	24	18
Practical	56	51	57	59	58	49	53	56	57	56	55	56	52	55	58
Lay psychological	46	39	36	36	31	23	41	35	27	39	32	32	42	34	23
Moral, self-help	44	59	57	59	68	70	54	62	66	55	65	60	43	62	66
Total per cent[b]	212	200	199	203	199	181	205	201	189	203	196	191	199	198	177
Number making any action suggestions	217	330	735	727	646	640	730	1,359	1,206	761	1,803	731	136	2,937	222

[a]See Table 56 for a definition of "involvement."

[b]Totals exceed 100% because respondents often made more than one kind of action suggestion.

TABLE 57--Continued

Action Suggested	Proportion of Respondents in Indicated Group Making Each Action Suggestion, Among Respondents Making Any Action Suggestion														
	Educational Attainment						Information Exposure			Contact with Psychiatric Patients			Summary[a]		
	College Graduate and Above	Some College	High School Graduate	Some High School	Grammar School Graduate	Less Than Grammar School Graduate	High Exposure (6 or More Sources)	Middle Exposure (3-5 Sources)	Low Exposure (0-2 Sources)	Non-Institutionalized Patients	Institutionalized Patients Only	None Reported	Highest Involvement	Intermediate Involvement	Lowest Involvement
For examples classed as MENTAL ILLNESS															
Psychiatric	45	47	40	33	22	24	45	33	26	44	28	40	55	34	21
Medical	8	8	15	18	20	19	11	15	20	8	17	21	6	16	26
Physical	9	6	6	9	8	9	7	8	8	6	9	6	6	8	16
Practical	5	8	4	5	11	6	5	6	8	4	7	8	4	6	14
Lay psychological	41	37	34	40	35	31	41	36	31	36	37	34	39	36	35
Moral, self-help	23	28	27	33	34	39	26	33	33	28	34	26	21	31	28
Total per cent[b]	131	134	126	138	130	128	135	131	126	126	132	135	131	131	140
Number making action suggestions for mental illness examples	111	139	279	257	195	140	323	495	303	321	576	224	67	1,011	43

TABLE 57--Continued

Action Suggested	Proportion of Respondents in Indicated Group Making Each Action Suggestion, Among Respondents Making Any Action Suggestion														
	Educational Attainment						Information Exposure			Contact with Psychiatric Patients			Summary[a]		
	College Graduate and Above	Some College	High School Graduate	Some High School	Grammar School Graduate	Less Than Grammar School Graduate	High Exposure (6 or More Sources)	Middle Exposure (3-5 Sources)	Low Exposure (0-2 Sources)	Non-Institutionalized Patients	Institutionalized Patients Only	None Reported	Highest Involvement	Intermediate Involvement	Lowest Involvement
Examples classed as SOMETHING ELSE WRONG[c]															
Psychiatric	12	7	7	4	2	3	8	6	2	9	4	3	15	5	1
Medical	3	3	5	5	3	6	4	5	4	5	4	5	5	5	3
Physical	31	25	22	25	26	25	25	24	25	24	27	21	22	26	17
Practical	46	46	45	46	42	35	43	43	41	45	43	42	45	43	43
Lay psychological	29	27	29	21	19	13	27	23	17	26	21	20	30	22	14
Moral, self-help	38	44	45	47	53	57	39	49	54	40	52	49	29	49	58
Total per cent[b]	159	152	153	148	145	139	146	150	143	149	151	140	146	150	136
Number making action suggestions for something else wrong	167	233	507	495	443	416	523	957	781	540	1,238	483	102	2,013	146

[c]Includes "something wrong" examples for which people said either that it wasn't mental illness or that they weren't sure whether or not it was.

TABLE 57--Continued

Action Suggested	Proportion of Respondents in Indicated Group Making Each Action Suggestion, Among Respondents Making Any Action Suggestion														
	Educational Attainment						Information Exposure			Contact with Psychiatric Patients			Summary[a]		
	College Graduate and Above	Some College	High School Graduate	Some High School	Grammar School Graduate	Less Than Grammar School Graduate	High Exposure (6 or More Sources)	Middle Exposure (3-5 Sources)	Low Exposure (0-2 Sources)	Non-Institutionalized Patients	Institutionalized Patients Only	None Reported	Highest Involvement	Intermediate Involvement	Lowest Involvement
For examples classed as NOTHING WRONG															
Psychiatric	2	2	2	2	*	*	3	1	*	3	1	1	4	1	-
Medical	1	1	1	1	1	1	2	*	1	1	1	1	-	1	1
Physical	9	5	7	7	8	9	6	7	8	8	8	7	4	8	5
Practical	60	46	59	56	50	47	51	53	53	57	51	53	59	52	54
Lay psychological	23	24	17	19	18	16	22	20	15	21	17	21	20	18	17
Moral, self-help	35	57	46	45	55	59	49	49	53	48	53	48	48	51	52
Total per cent[b]	130	135	132	130	132	132	133	130	130	138	131	131	135	131	129
Number making action suggestion for nothing wrong examples	86	153	392	440	419	427	350	776	791	385	1,071	461	46	1,726	145

*Less than 0.5%.

TABLE 58

AGE-EDUCATION DIFFERENCES IN CONCEPTIONS OF MENTAL ILLNESS

Conception of Mental Illness	Proportion of Indicated Age-Educational Group with Each Conception of Mental Illness											
	Any College				Any High School				Grammar School Only			
	Under 40	40-49	50-59	60- and Over	Under 40	40-49	50-59	60- and Over	Under 40	40-49	50-59	60- and Over
GENERAL CONCEPTIONS												
First impression spontaneously included non-psychotic syndromes	57	65	53	34	43	50	47	46	38	42	39	38
Mental illness included more than "insanity"	94	93	91	76	87	87	85	82	76	75	77	70
"Nervous breakdown" was mental illness	64	64	59	48	49	51	50	46	36	39	40	44
Total Usage: Consistent non-psychotic	44	48	36	27	29	31	34	27	19	20	21	22
Inconsistent non-psychotic	43	44	49	41	49	50	49	48	44	51	45	44
Inconsistent psychotic	11	6	13	24	16	13	13	16	21	14	18	16
Consistent psychotic	2	1	2	8	5	6	3	8	9	11	10	12
No impression	*	1	*	*	1	*	1	1	7	4	6	6
Total per cent	100	100	100	100	100	100	100	100	100	100	100	100
CONCRETE PERCEPTIONS (Proportion classifying examples as mentally-ill)												
"Frank Jones" (Paranoid)	85	89	86	76	75	81	77	82	65	69	69	74
"Betty Smith" (Simple Schizophrenic)	52	51	26	46	31	33	33	42	23	31	28	33
"Bill Williams" (Alcoholic)	51	50	33	36	29	29	33	25	16	17	22	21
"George Brown" (Anxiety Neurotic)	26	29	21	30	15	14	17	23	12	14	20	21
"Bobby Grey" (Conduct Disturbance)	25	23	15	20	13	15	17	18	7	7	9	14
"Mary White" (Compulsive-Phobic)	16	13	4	10	5	5	3	8	4	5	8	8
At least one of above	93	95	93	85	82	89	84	89	71	78	78	80
Four-question summary:												
Personality disorder (and all others below) included	9	11	4	7	2	3	1	4	2	2	3	4
Neurosis (and all others below) included	13	12	6	15	7	7	9	8	4	6	9	10
Limited to psychosis, generally	24	24	16	19	18	18	20	25	14	17	12	15
Limited to violent psychosis	30	35	51	27	41	48	39	33	39	38	37	38
No apparent recognition	12	6	12	17	22	15	19	13	32	25	25	22
Usage not consistently classifiable	12	12	11	15	10	9	12	17	9	12	14	11
Total per cent	100	100	100	100	100	100	100	100	100	100	100	100
LOGICAL CRITERIA												
Descriptive: Emotional-functional deviancy	63	68	52	58	48	50	45	47	34	45	44	37
Cognitive-control deviancy	20	14	23	17	28	29	29	28	33	28	30	32
General deviancy	17	18	25	25	24	21	26	25	33	27	26	31
Total per cent	100	100	100	100	100	100	100	100	100	100	100	100
Non-descriptive: Organic disease	21	24	27	25	21	20	20	22	19	18	16	19
Non-physical disorder	31	30	30	27	32	34	43	44	28	37	34	23
Counter-reality, inexplicable behavior	64	63	75	58	65	62	65	69	53	56	59	57
Volitional defect	44	48	43	31	37	39	42	45	27	32	31	37
Involuntary action	26	26	30	34	25	25	33	33	28	24	30	32
Descriptive only	11	9	4	10	12	9	10	4	17	12	15	16
Total per cent[a]	197	200	209	185	192	189	213	217	172	179	185	184
Logical consistency: Contradicted own criteria	83	87	89	90	83	84	86	86	74	77	73	72
Number of cases	315	159	73	59	935	306	183	130	357	272	304	438

*Less than 0.5%.

[a]Totals exceed 100% because respondents often employed more than one criterion.

TABLE 59

AGE-EDUCATIONAL DIFFERENCES IN EXPLANATIONS OF HUMAN BEHAVIOR

Cause	Any College				Any High School				Grammar School Only			
	Under 40	40–49	50–59	60 and Over	Under 40	40–49	50–59	60 and Over	Under 40	40–49	50–59	60 and Over
Proportion of ALL RESPONDENTS in group												
Organic processes directly affecting brain, nervous system	25	31	47	49	31	38	40	54	41	46	48	46
Diffuse physical processes	18	26	29	32	25	27	27	33	26	30	35	29
Innate personality, will, choice	34	41	52	51	39	43	45	53	42	45	47	49
External environment, circumstances	81	75	78	76	79	80	70	75	68	68	74	71
Direct, equivalent conditioning	88	87	92	88	91	92	90	88	86	88	87	78
Other psychodynamic relationships	78	82	67	66	65	60	63	64	47	41	46	43
No causal explanation	*	1	1	*	1	1	*	*	2	1	2	2
Total per cent[a]	324	343	366	362	331	341	335	367	312	319	339	318
Number of respondents	315	159	73	59	935	306	183	130	357	272	304	438
Proportion of ALL EXAMPLES discussed by respondents in group												
Organic processes directly affecting brain, nervous system	5	7	11	12	6	9	10	12	9	10	11	11
Diffuse physical processes	3	5	8	7	5	5	6	7	5	6	8	6
Innate personality, will, choice	8	9	12	13	8	10	10	13	9	10	10	12
External environment, circumstances	26	22	23	25	24	24	22	24	19	20	21	22
Direct, equivalent conditioning	33	33	35	31	38	38	36	32	32	33	32	28
Other psychodynamic relationships	25	27	21	18	18	17	17	17	11	10	10	10
No causal explanation	25	25	21	23	25	24	25	27	34	32	29	34
Total per cent[b]	125	128	131	129	124	127	126	132	119	121	121	123
Number of examples discussed	1890	954	438	354	5610	1836	1098	780	2142	1632	1824	2628
Proportion of EXAMPLES CAUSALLY EXPLAINED by respondents in group												
Organic processes directly affecting brain, nervous system	7	10	14	16	9	11	13	17	14	15	16	17
Diffuse physical processes	5	7	10	9	6	7	8	9	8	9	11	9
Innate personality, will, choice	10	12	16	17	11	13	14	19	13	15	15	18
External environment, circumstances	34	30	29	33	33	32	29	33	29	29	30	32
Direct, equivalent conditioning	44	44	45	40	50	51	48	44	48	48	45	42
Other psychodynamic relationships	33	36	26	24	24	22	23	23	16	15	15	14
Total per cent[b]	133	139	140	139	133	136	135	145	128	131	132	132
Number of examples causally explained	1423	712	347	272	4210	1391	826	566	1418	1109	1288	1744

*Less than 0.5%.

[a]Totals exceed 100% because most respondents used more than one causal explanation in the course of discussing the six examples.

[b]Totals exceed 100% because some respondents used more than one causal explanation in the course of discussing a single example.

TABLE 60

AGE-EDUCATIONAL DIFFERENCES IN PROPOSED CORRECTIVE SOLUTIONS OF HUMAN BEHAVIOR

Action Suggested	Proportion of Respondents in Indicated Group Making Each Action Suggestion, Among Respondents Making Any Action Suggestion											
	Any College				Any High School				Grammar School Only			
	Under 40	40-49	50-59	60 and Over	Under 40	40-49	50-59	60 and Over	Under 40	40-49	50-59	60 and Over
For any example												
Psychiatric	28	28	20	21	16	19	15	20	7	8	8	7
Medical	6	7	4	9	8	10	11	14	9	7	9	9
Physical	25	26	23	21	20	23	28	25	22	25	26	23
Practical	54	56	51	39	61	56	54	51	51	50	57	55
Lay psychological	40	42	50	39	32	42	40	41	25	27	31	27
Moral, self-help	49	50	64	66	56	55	65	73	69	65	69	73
Total per cent[a]	202	209	212	195	193	205	213	224	183	182	200	194
Number making any action suggestions	277	144	70	56	875	289	173	125	330	255	291	410
For examples classed as MENTAL ILLNESS												
Psychiatric	50	46	30	b	41	36	26	31	22	22	25	21
Medical	7	9	7		15	16	13	26	19	14	20	22
Physical	8	7	-		8	7	9	2	9	8	11	7
Practical	6	12	4		5	3	3	9	9	10	9	8
Lay psychological	36	38	59		36	46	32	33	26	42	39	28
Moral, self-help	24	24	33		26	27	44	38	34	26	38	43
Total per cent[a]	131	136	133		131	135	127	139	119	122	142	129
Number making action suggestions for mental illness examples	135	68	27	20	298	111	69	58	77	72	79	107
For examples classed as SOMETHING ELSE WRONG[c]												
Psychiatric	6	11	12	12	4	7	7	11	2	4	2	2
Medical	3	3	2	5	4	6	8	8	5	4	5	4
Physical	28	26	24	25	22	23	26	26	23	27	29	25
Practical	48	50	41	25	47	48	37	44	41	36	40	38
Lay psychological	25	30	32	22	24	28	25	22	14	16	20	15
Moral, self-help	36	36	49	58	44	44	49	59	55	53	51	58
Total per cent[a]	146	156	160	147	145	156	152	170	140	140	147	142
Number making action suggestions for something else wrong examples	195	106	59	40	583	205	126	88	208	162	202	287
For examples classed as NOTHING WRONG												
Psychiatric	1	2	6	3	1	6	1	1	-	1	1	-
Medical	1	2	-	-	1	1	-	-	1	1	1	1
Physical	5	8	10	3	5	7	13	10	9	12	6	7
Practical	55	54	42	39	61	54	57	46	45	47	53	49
Lay psychological	24	22	29	21	17	23	19	28	16	17	15	19
Moral, self-help	50	43	55	55	45	43	42	54	60	57	57	54
Total per cent[a]	136	131	142	121	130	134	132	139	131	135	133	130
Number making action suggestion for nothing wrong examples	116	59	31	33	501	165	99	67	222	166	187	271

*Less than 0.5%.

[a]Totals exceed 100% because respondents often made more than one kind of action suggestion.

[b]Too few cases to report percentages.

[c]Includes "something wrong" examples for which people said either that it wasn't mental illness or that they weren't sure whether or not it was.

TABLE 61

SOME DEMOGRAPHIC DIFFERENCES IN CONTACT WITH AND INFORMATION ABOUT MENTAL ILLNESS

Social Factor	Number of Cases	Median Years of Education	Mean Number of Information Sources	Proportion Knowing			Proportion with Highest Involvement[a]
				Any Psychotic Patient	Hospitalized Patient	Extra-Mural Patient	
Age							
21-29	695	12.1	4.2	70	64	24	7
30-39	912	11.9	3.8	78	74	26	5
40-49	737	10.7	3.8	79	76	28	6
50-59	560	8.8	3.3	81	78	21	3
60-69	425	8.4	2.6	80	76	16	2
70 and over	202	8.2	2.4	84	83	8	1
Sex							
Men	1,736	10.4	3.5	77	74	22	5
Women	1,795	10.7	3.6	79	74	24	4
Race							
White	3,209	10.8	3.6	78	74	24	5
Colored	322	8.8	3.5	74	73	13	2
Religion							
Protestant	2,396	10.6	3.5	80	76	22	4
Catholic	819	10.0	3.6	73	69	23	4
Jewish	136	12.3	4.8	76	63	46	15
Other	58	11.8	4.2	79	72	28	7
None	122	8.9	3.0	71	63	23	4
Occupation							
Professional	234	16.1	5.3	85	74	44	27
Managerial	213	12.3	3.7	83	78	28	7
Clerical	312	12.2	3.9	79	74	23	7
Service (except domestic)	176	8.8	3.4	81	78	18	-
Skilled	342	9.7	3.4	74	70	20	1
Semi-skilled	331	8.9	3.2	73	72	11	1
Unskilled (including domestic service and farm labor)	220	8.3	2.9	69	68	10	-
Farmers	242	8.7	2.7	83	83	13	1
Not gainfully employed	1,461	10.7	3.6	78	73	19	11
Gross Annual Family Income							
$10,000 and over	77	13.9	4.7	90	78	49	17
$ 7,500-$9,999	85	12.9	4.7	92	82	48	19
$ 5,000-$7,499	253	12.7	4.5	82	76	35	16
$ 4,000-$4,999	392	12.1	4.1	82	76	33	5
$ 3,000-$3,999	763	12.0	3.9	76	72	26	5
$ 2,000-$2,999	870	10.2	3.5	76	74	18	2
$ 1,000-$1,999	538	9.2	3.0	75	73	16	1
Under $1,000	427	8.1	2.6	80	77	13	1
Income not reported	126	9.3	3.1	69	64	17	3
Region of Residence							
East	1,001	11.0	3.8	78	73	27	6
Middle West	1,057	10.3	3.5	76	73	21	4
West	437	11.5	3.8	77	71	27	6
South	1,036	9.2	3.4	81	78	19	4
Place of Residence							
Metropolitan Center (over 1,000,000)	972	11.0	3.8	73	66	27	6
City (50,000-1,000,000)	892	10.8	3.7	76	71	26	5
Town (2,500-50,000)	553	10.7	3.4	80	76	22	4
Village (under 2,500)	537	10.3	3.4	84	83	20	4
Farm	577	9.2	3.3	82	81	17	3

[a]See Table 56 for a definition of "involvement."

TABLE 62

SOME DEMOGRAPHIC DIFFERENCES IN CONCEPTIONS OF MENTAL ILLNESS

A.: Age Differences

Conception of Mental Illness	Proportion of Each Age Group with Indicated Conception of Mental Illness					
	21-29	30-39	40-49	50-59	60-69	70 and Over
GENERAL CONCEPTIONS						
First impression spontaneously included non-psychotic syndromes	42	47	50	43	41	34
Mental illness included more than "insanity"	89	83	84	82	74	70
"Nervous breakdown" was mental illness	48	49	48	46	46	37
Total Usage: Consistent non-psychotic	29	30	31	27	25	21
Inconsistent non-psychotic	46	47	49	47	44	45
Inconsistent psychotic	18	15	12	16	15	19
Consistent psychotic	4	5	6	6	11	11
No impression	3	3	2	4	5	4
Total per cent	100	100	100	100	100	100
CONCRETE PERCEPTIONS (Proportion classifying examples as mentally-ill)						
"Frank Jones" (Paranoid)	73	76	78	74	74	80
"Betty Smith" (Simple Schizophrenic)	33	34	36	30	35	38
"Bill Williams" (Alcoholic)	31	30	29	27	23	23
"George Brown" (Anxiety Neurotic)	16	17	17	19	19	29
"Bobby Grey" (Conduct Disturbance)	14	14	14	12	14	18
"Mary White" (Compulsive-Phobic)	6	7	7	6	7	11
At least one of above	81	84	86	82	81	86
Four-question summary:						
Personality disorder (and all others below) included	3	3	4	2	3	7
Neurosis (and all others below) included	7	8	8	9	9	13
Limited to psychosis, generally	18	19	19	15	19	14
Limited to violent psychosis	38	39	41	40	35	37
No apparent recognition	23	21	17	22	21	16
Usage not consistently classifiable	11	10	11	12	13	13
Total per cent	100	100	100	100	100	100
LOGICAL CRITERIA						
Descriptive: Emotional-functional deviancy	48	48	52	45	42	39
Cognitive-control deviancy	26	28	26	29	28	33
General deviancy	26	24	22	26	30	28
Total per cent	100	100	100	100	100	100
Non-descriptive: Organic disease	20	20	20	19	20	22
Non-physical disorder	27	33	35	36	26	30
Counter-reality, inexplicable behavior	61	62	60	63	60	58
Volitional defect	36	37	38	36	36	44
Involuntary action	23	28	25	31	31	36
Descriptive only	14	13	10	12	14	11
Total per cent[a]	181	193	188	197	187	201
Logical consistency: Contradicted own criteria	80	80	82	79	77	77
Number of cases	695	912	737	560	425	202

[a]Totals exceed 100% because respondents often employed more than one criterion.

TABLE 62--Continued

B.: Sex Differences

Conception of Mental Illness	Proportion of Each Sex with Indicated Conception of Mental Illness	
	Men	Women
GENERAL CONCEPTIONS		
First impression spontaneously included non-psychotic syndromes	42	47
Mental illness included more than "insanity"	81	84
"Nervous breakdown" was mental illness	51	45
Total Usage: Consistent non-psychotic	30	27
Inconsistent non-psychotic	43	49
Inconsistent psychotic	16	15
Consistent psychotic	8	6
No impression	3	3
Total per cent	100	100
CONCRETE PERCEPTIONS (Proportion classifying examples as mentally-ill)		
"Frank Jones" (Paranoid)	76	75
"Betty Smith" (Simple Schizophrenic)	35	33
"Bill Williams" (Alcoholic)	30	27
"George Brown" (Anxiety Neurotic)	20	16
"Bobby Grey" (Conduct Disturbance)	15	13
"Mary White" (Compulsive Phobic)	8	6
At least one of above	84	82
Four-question summary:		
Personality disorder (and all others below) included	4	3
Neurosis (and all others below) included	9	8
Limited to psychosis, generally	17	18
Limited to violent psychosis	37	40
No apparent recognition	20	21
Usage not consistently classifiable	13	10
Total per cent	100	100
LOGICAL CRITERIA		
Descriptive: Emotional-functional deviancy	48	47
Cognitive-control deviancy	28	27
General deviancy	24	26
Total per cent	100	100
Non-descriptive: Organic disease	21	20
Non-physical disorder	32	33
Counter-reality, inexplicable behavior	61	61
Volitional defect	39	35
Involuntary action	28	27
Descriptive only	12	13
Total per cent[a]	193	189
Logical consistency: Contradicted own criteria	79	81
Number of cases	1,736	1,795

TABLE 62—Continued

C.: Racial Differences

Conception of Mental Illness	Proportion of Each Race with Indicated Conception of Mental Illness	
	White	Colored
GENERAL CONCEPTIONS		
First impression spontaneously included non-psychotic syndromes	47	30
Mental illness included more than "insanity"	84	68
"Nervous breakdown" was mental illness	49	37
Total Usage: Consistent non-psychotic	30	19
Inconsistent non-psychotic	47	43
Inconsistent psychotic	15	17
Consistent psychotic	5	16
No impression	3	5
Total per cent	100	100
CONCRETE PERCEPTIONS (Proportion classifying examples as mentally-ill)		
"Frank Jones" (Paranoid)	76	68
"Betty Smith" (Simple Schizophrenic)	33	46
"Bill Williams" (Alcoholic)	29	24
"George Brown" (Anxiety Neurotic)	18	23
"Bobby Grey" (Conduct Disturbance)	14	12
"Mary White" (Compulsive-Phobic)	7	9
At least one of above	84	79
Four-question summary:		
Personality disorder (and all others below included	3	5
Neurosis (and all others below) included	8	11
Limited to psychosis, generally	17	22
Limited to violent psychosis	41	23
No apparent recognition	20	23
Usage not consistently classifiable	11	16
Total per cent	100	100
LOGICAL CRITERIA		
Descriptive: Emotional-functional deviancy	48	45
Cognitive-control deviancy	27	33
General deviancy	25	22
Total per cent	100	100
Non-descriptive: Organic disease	21	16
Non-physical disorder	33	27
Counter-reality, inexplicable behavior	63	47
Volitional defect	38	31
Involuntary action	28	28
Descriptive only	12	19
Total per cent[a]	195	168
Logical consistency: Contradicted own criteria	81	64
Number of cases	3,209	322

TABLE 62--Continued

D.: Religious Differences

Conception of Mental Illness	Proportion of Respondents of Each Religious Affiliation with Indicated Conception of Mental Illness				
	Protestant	Catholic	Jewish	Other	None
GENERAL CONCEPTIONS					
First impression spontaneously included non-psychotic syndromes	40	43	59	47	39
Mental illness included more than "insanity"	81	86	89	84	76
"Nervous breakdown" was mental illness	47	46	58	59	41
Total Usage: Consistent non-psychotic	28	27	44	41	26
Inconsistent non-psychotic	46	51	43	33	34
Inconsistent psychotic	16	15	9	13	21
Consistent psychotic	7	4	4	10	15
No impression	3	3	-	3	4
Total per cent	100	100	100	100	100
CONCRETE PERCEPTIONS (Proportion classifying examples as mentally-ill)					
"Frank Jones" (Paranoid)	76	71	79	85	78
"Betty Smith" (Simple Schizophrenic)	35	28	45	43	31
"Bill Williams" (Alcoholic)	30	23	39	29	30
"George Brown" (Anxiety Neurotic)	19	14	20	26	20
"Bobby Grey" (Conduct Disturbance)	14	12	20	19	16
"Mary White" (Compulsive-Phobic)	7	6	10	5	11
At least one of above	85	78	89	86	80
Four-question summary:					
Personality disorder (and all others below) included	4	2	5	2	7
Neurosis (and all others below) included	9	6	11	20	8
Limited to psychosis, generally	18	17	21	17	12
Limited to violent psychosis	39	39	34	40	44
No apparent recognition	19	25	17	14	21
Usage not consistently classifiable	11	11	12	7	8
Total per cent	100	100	100	100	100
LOGICAL CRITERIA					
Descriptive: Emotional-functional deviancy	47	46	58	61	45
Cognitive-control deviancy	29	25	24	24	30
General deviancy	24	29	18	15	25
Total per cent	100	100	100	100	100
Non-descriptive: Organic disease	21	18	18	28	18
Non-physical disorder	32	33	30	31	33
Counter-reality, inexplicable behavior	61	60	61	71	57
Volitional defect	39	32	35	43	36
Involuntary action	28	29	18	22	25
Descriptive only	12	14	12	7	14
Total per cent[a]	193	186	174	202	183
Logical consistency: Contradicted own criteria	80	78	84	88	71
Number of cases	2,396	819	136	58	122

TABLE 63

SOME DEMOGRAPHIC DIFFERENCES IN CAUSAL EXPLANATIONS OF HUMAN BEHAVIOR

Social Factor	Number of Cases		Mean Number of Examples Explained	Proportion of Respondents in Indicated Group Using Each Cause to Explain Any Example						Proportion of All Examples Explained by Indicated Group Explained by Each Cause					
	Respondents	Examples Explained		Direct Brain, Nervous System Processes	Diffuse Physical Factors	Innate Personality, Will, Choice	External Environment, Circumstances	Direct Equivalent Conditioning	Psychodynamic Relationships	Direct Brain, Nervous System Processes	Diffuse Physical Factors	Innate Personality, Will, Choice	External Environment, Circumstances	Direct Equivalent Conditioning	Psychodynamic Relationships
Age															
21-29	695	3,114	4.5	27	20	39	79	92	65	8	5	11	31	51	24
30-39	912	3,937	4.3	35	27	39	76	87	63	10	7	12	33	48	24
40-49	737	3,212	4.4	38	28	44	74	89	58	12	8	14	30	48	23
50-59	560	2,461	4.4	46	31	46	73	89	55	15	10	15	30	46	19
60-69	425	1,762	4.1	47	30	47	77	81	48	16	9	16	33	43	18
70 and over	202	820	4.1	55	31	54	64	82	44	19	10	22	30	41	15
Sex															
Men	1,736	7,506	4.3	41	24	43	76	88	55	13	7	14	33	49	20
Women	1,795	7,800	4.3	36	30	43	74	87	62	11	9	13	31	46	24
Race															
White	3,209	13,997	4.3	38	28	42	77	88	60	11	8	13	32	47	22
Colored	322	1,309	4.1	42	18	53	63	86	45	14	6	18	24	46	16
Religion															
Protestant	2,396	10,349	4.3	40	29	45	73	87	58	13	8	15	30	46	22
Catholic	819	3,539	4.3	33	25	37	78	87	58	10	7	11	34	49	22
Jewish	136	654	4.8	36	21	39	88	93	71	10	5	12	40	50	29
Other	58	277	4.8	45	28	43	86	97	60	12	7	12	34	50	20
None	122	487	4.0	38	19	39	72	84	52	12	6	12	33	44	22

TABLE 63--Continued

Social Factor	Number of Cases		Mean Number of Examples Explained	Proportion of Respondents in Indicated Group Using Each Cause to Explain Any Example						Proportion of All Examples Explained by Indicated Group Explained by Each Cause					
	Respondents	Examples Explained		Direct Brain, Nervous System Processes	Diffuse Physical Factors	Innate Personality, Will, Choice	External Environment, Circumstances	Direct Equivalent Conditioning	Psychodynamic Relationships	Direct Brain, Nervous System Processes	Diffuse Physical Factors	Innate Personality, Will, Choice	External Environment, Circumstances	Direct Equivalent Conditioning	Psychodynamic Relationships
Occupation															
Professional	234	1,098	4.7	40	22	40	79	90	77	12	6	12	35	44	31
Managerial	213	960	4.5	33	30	44	82	87	63	10	8	14	33	47	24
Clerical	312	1,384	4.4	35	23	45	77	88	63	11	7	14	34	48	22
Service (except domestic)	176	735	4.2	44	30	46	74	85	52	15	8	16	29	46	19
Skilled	342	1,534	4.5	38	27	44	75	91	56	11	6	13	31	52	19
Semi-skilled	331	1,439	4.3	44	27	40	77	88	52	13	8	12	33	51	18
Non-skilled (including domestic service and farm labor)	220	908	4.1	44	21	53	68	87	40	15	6	16	29	47	13
Farmers	242	934	3.9	45	25	46	65	88	48	16	8	18	28	44	16
Not gainfully employed	1,461	6,314	4.3	36	30	41	75	87	61	11	9	13	31	46	24
Gross Annual Family Income															
$10,000 and over	77	366	4.8	31	14	46	85	95	77	9	4	15	33	48	36
$7,500-$9,999	85	388	4.6	33	32	35	75	88	81	11	8	10	31	41	32
$5,000-$7,499	253	1,171	4.6	34	25	44	78	88	67	10	7	14	34	45	27
$4,000-$4,999	392	1,760	4.5	36	26	41	78	92	69	11	7	13	33	48	26
$3,000-$3,999	763	3,425	4.5	33	28	40	80	89	59	10	7	12	33	50	22
$2,000-$2,999	870	3,745	4.3	38	29	41	74	88	60	12	8	12	30	49	22
$1,000-$1,999	538	2,222	4.1	42	28	44	69	86	52	14	9	15	29	46	19
Under $1,000	427	1,722	4.0	50	26	52	68	81	44	18	8	19	29	42	15
Income not reported	126	507	4.0	43	25	42	77	87	52	14	7	13	33	48	18
Region of Residence															
East	1,001	4,489	4.5	33	22	40	80	92	59	10	6	12	34	52	22
Middle West	1,057	4,284	4.1	36	28	41	72	83	58	12	8	13	31	45	22
West	437	1,939	4.4	43	27	41	76	89	64	13	7	13	31	45	25
South	1,036	4,594	4.4	44	30	49	73	88	56	14	9	16	29	45	20
Place of Residence															
Metropolitan Center (over 1,000,000)	972	4,273	4.4	35	22	39	78	88	61	11	6	13	34	48	25
City (50,000-1,000,000)	892	3,936	4.4	37	27	42	78	89	60	11	7	13	32	50	23
Town (2,500-50,000)	553	2,420	4.4	41	35	42	77	87	60	13	10	12	31	45	22
Village (under 2,500)	537	2,351	4.4	39	29	49	73	88	58	12	8	15	30	48	21
Farm	577	2,326	4.0	42	26	45	67	86	52	15	9	16	29	43	18

TABLE 64

SOME DEMOGRAPHIC DIFFERENCES IN PROPOSED CORRECTIVE SOLUTIONS OF HUMAN BEHAVIOR

Social Factor	Number Making Any Action Suggestion	Proportion of Respondents in Indicated Group Making Any Action Suggestion Proposing Each Type of Action for Any Example					
		Psychiatric	Medical	Physical	Practical	Lay Psychological	Moral, Self-Help
Age							
21-29	642	17	7	18	60	33	55
30-39	840	16	8	24	56	32	59
40-49	688	17	8	24	54	36	58
50-59	534	12	9	26	55	36	67
60-69	404	12	11	24	55	33	70
70 and over	187	9	7	23	47	27	76
Sex							
Men	1,607	13	7	24	58	33	63
Women	1,688	17	4	23	53	33	61
Race							
White	2,993	15	8	24	57	33	61
Colored	302	9	8	20	42	34	70
Religion							
Protestant	2,240	13	8	24	55	32	63
Catholic	762	15	10	21	57	37	61
Jewish	126	40	9	17	56	34	43
Other	54	24	6	22	56	46	68
None	113	13	4	24	45	29	60

TABLE 64--Continued

Social Factor	Number Making Any Action Suggestion	Proportion of Respondents in Indicated Group Making Any Action Suggestion Proposing Each Type of Action for Any Example					
		Psychiatric	Medical	Physical	Practical	Lay Psychological	Moral, Self-Help
Occupation							
Professional	207	32	7	28	55	41	49
Managerial	197	16	7	27	57	39	55
Clerical	289	16	8	21	59	39	59
Service (except domestic)	167	10	8	26	57	30	66
Skilled	322	12	7	25	62	32	66
Semi-skilled	317	11	9	22	56	32	62
Non-skilled (including domestic service and farm labor)	202	3	6	22	43	28	71
Farmers	207	4	7	27	63	27	81
Not gainfully employed	1,370	17	10	22	54	33	60
Gross Annual Family Income							
$10,000 and over	69	26	9	28	57	41	49
$7,500-$9,999	63	25	7	19	62	41	42
$5,000-$7,499	230	23	9	26	58	38	50
$4,000-$4,999	365	19	7	24	58	35	61
$3,000-$3,999	719	19	9	23	60	38	58
$2,000-$2,999	817	11	7	23	57	30	63
$1,000-$1,999	501	12	9	24	50	31	66
Under $1,000	399	5	9	21	46	28	74
Income not reported	122	14	7	23	59	35	62
Region of Residence							
East	945	17	10	21	59	38	56
Middle West	992	12	7	22	56	31	66
West	403	23	9	24	58	38	55
South	955	11	8	27	50	30	66
Place of Residence							
Metropolitan Center (over 1,000,000)	903	22	9	19	58	37	55
City (50,000-1,000,000)	846	15	9	26	56	36	61
Town (2,500-50,000)	513	15	8	25	53	34	61
Village (under 2,500)	501	10	7	23	55	32	65
Farm	532	6	8	25	54	27	71