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Are the Ranks Closed? Attitudinal Social Distance and Mental Illness

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The authors review previous studies on social attitudes toward the mentally ill and present data from their field survey on the opinions and attitudes of a blue-collar population toward mental illness. Almost all the 937 respondents considered mental illness an illness requiring the care of a physician and one that can be cured with proper treatment. Responses to questions about social distance showed significantly greater acceptance than rejection of all those who were formerly mentally ill.

THE IMAGE OF rank on rank closed to those classified as mentally ill is dramatic and tenacious but perhaps inaccurate. The idea that mental health professionals care for their patients in the face of a hostile populace that neither understands nor accepts may be somewhat quixotic in the light of newer evidence. In this paper we shall: 1) review previous studies of social distance from the mentally ill, and 2) present data from a field study conducted in a homogeneous population purported to harbor negative attitudes toward the mentally ill.

The establishment of the National Institute of Mental Health in 1946 and the involvement of the federal and state governments in mental health programs in the late 1940s inspired several assessments of public attitudes about mental illness (1–6). The primary concern at the time was evaluation of the popular support needed to endorse the expenditures required by these programs. The enactment of the Community Mental Health Centers Act of 1963 and its expansion in Public Law 89-105 in 1965, with emphasis on community-based treatment of the mentally ill, have made public attitudes toward mental illness one of the most important factors in the management of mental illness. Success of community psychiatric programs and development of alternatives to hospitalization for persons suffering from mental illness depend, in a large measure, on a favorable climate of opinion in the community.

Review of the Literature

Since its first use by Bogardus in 1925 (7), the concept of social distance has been mainly devoted to social response to ethnic groups. The literature on attitudinal distance from the mentally ill is of later origin and is sparser. In 1943 Allen (8) stated that public feeling about the mentally ill was characterized by fear, stigmatization, and rejection. Bingham reported essentially the same findings in 1951 (9). However, as early as 1948 Ramsey and Siepp (4) noticed that the public was moving toward a humanitarian and scientific point of view toward mental illness, and Woodward, in a study done in Louisville, Ky., in 1950 (6), reached similar conclusions.

Among the earlier studies, the most published and most quoted is that of Star (5).

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This study, originally titled "The Dilemma of Mental Illness," was carried out in 1950 and was based on interviews of 3,500 persons in a national sample. Star's conclusions were that people were greatly rejecting of the mentally ill and admitted only extreme psychoses, accompanied by threatening assaultive behavior, into their actual working definition of such illness. This survey included six case descriptions of mentally ill persons: a paranoid schizophrenic, a simple schizophrenic, a chronic anxiety neurotic, a compulsive phobic, an alcoholic, and a 12-year-old with a behavior disorder. These cases achieved standard use in subsequent studies.

Although it was published in 1957, the field survey for *Closed Ranks* (1) was carried out in 1951. John and Elaine Cumming conducted a field experiment in two small Canadian towns. The people of one town were subjected to a program of intensive mental health education; the people of the other town served as the control group. Attitudes in both towns were surveyed before and after the educational program. The Cummings' conclusion was that public attitudes toward mental illness were those of "denial, isolation, and insulation of mental illness" (p. 119); hence the community's remarkable tolerance for deplorable conditions in mental hospitals, the patients' physical and social isolation, and the community's rejection of ex-mental patients. They theorized that this was necessary for "the reaffirmation of the solidarity of the social system in which the norms are not violated" (p. 127). They also postulated another function for the isolation of the mentally ill: that of reducing the guilt of those whose close ones have been sent off to the state hospitals. These attitudes persisted despite the educational program.

Nunnally (3) carried out an ambitious five-year study during 1954–59. Using the semantic differential, this researcher concluded that public attitudes were negative and that the public was uninformed rather than misinformed about mental illness. Other studies concerned themselves with the relationship of expressed opinion to action (10) and employer attitudes in relation to hiring the mentally ill (11, 12). Several authors found fault with the terms "mental illness" and "mental health" (13–15). They felt that much confusion had resulted from viewing these two as opposite ends of the same continuum.

By the late 1950s, Ridenour (15) and Gurin and associates (2) found much improvement in individual attitudes toward mental illness. Many positive concepts of mental health had been accepted, and people showed a willingness to admit their illness and seek psychiatric help. The Joint Commission on Mental Illness and Health, a composite of 36 national and public organizations established in 1955, published its final report, *Action for Mental Health*, in 1961 (16). Greatly influenced by the findings of Star (5), the Cummings (1), and Nunnally (3), this report paints a picture of rejection and punitive social response to mental illness with a major lack of recognition of mental illness as illness and a predominant tendency toward rejection of both mental patients and those who treat them. The report further describes "a pervasive defeatism" concerning the mentally ill.

These assertions were in marked contrast with the 1960 findings of Lemkau and Crocetti (17, 18). In this study, a probability sample of 1,737 residents of Baltimore, Md., was interviewed. Most questions used were identical with those used in previous surveys and included three of the six Star case descriptions. The sample population proved "fairly well informed," and showed "understanding and tolerance for the mentally ill." The majority identified given descriptions of behavior as indicative of mental illness, felt that the patient should see a physician, and were in favor of treating the mentally ill in the community. These findings were markedly inconsistent with "denial, rejection, and isolation." Many subsequent studies have confirmed the Baltimore findings (15, 18–24).

The similarity between social responses to members of ethnic outgroups and to the mentally ill has been of interest. Goffman noted that these two groups can be classified among a more general category of persons who bear a "stigma" (25). Harding and others (26) defined prejudice as a departure from some ideal norm of human relationship. Stereotyping is defined by Allport (27) as "an exaggerated belief associated with a

category" in order "to justify (rationalize) our conduct with respect to that category." Using the above definitions, Chin-Shong (28) found some similarity between the response to ethnic outgroups and to the mentally ill. Other studies have shown that the "authoritarian" personality has been positively correlated with prejudice (29) and with the rejection of the mentally ill (30, 31). What emerges with clarity is that those researchers who believe that there is a stigma attached to the mentally ill have found them to be generally rejected (1, 16, 32, 33).

Factors in Social Distance

What of the factors that influence attitudinal social distance? The body of literature shows a high consensus that better educated persons tend to be more enlightened, more humanitarian, and more scientific about mental illness. These observations were noted in one of the earliest surveys made (4) and were confirmed in several later surveys (1, 6, 34, 35). However, Freeman and Kassebaum (36) found that education had little effect on attitudes to mental illness, as did Nunnally on a semantic differential scale (3). Phillips indicated that rejection of the mentally ill is based more on their deviation from the norms of the expected behavior than on other factors (37). With regard to social class, Dohrenwend and Chin-Shong (35) noted that when a pattern of behavior is defined as seriously deviant by both lower and upper status groups, the lower status groups are less tolerant.

Acceptance of the mentally ill seems to be negatively correlated with age; younger people are less likely to reject the mentally ill (6, 17, 28, 34, 36, 37). The effect of personal acquaintance with hospital patients is of interest. Phillips found that in going from "no acquaintance" to "friend" to "family" there was reduced attitudinal distance (32). Swingle, interviewing visitors to hospitalized patients, found that the non-related visitors were more accepting of the patients than their visiting relatives (38). Freeman found relatives more accepting of the ex-mental patient, though they still showed a good deal of attitudinal social distance (39). Chin-Shong demonstrated more acceptance when there was a close tie to a hospital patient (28).

Where do people seek help for emotional disorders? Halpert (40) stated that "Studies made at intervals from 1950 to the present indicate that there has been little change in the public's reluctance or inability to seek psychiatric care for such disorders." He based this conclusion on three studies: a 1950 study in Louisville (6), the final report of the Joint Commission on Mental Illness and Health (16), and a 1963 study in New York City (22). Phillips has claimed that the mentally ill person is increasingly rejected as he moves along a continuum from not seeking help to seeking psychiatric help to utilizing a mental hospital (37). In contrast, in the Baltimore study (18) and the Kentucky study of 1964 (21), the vast majority of respondents knew that the patient should seek medical help. In a study in rural North Carolina (24), 31 percent of the respondents thought that a physician other than a psychiatrist was needed to help improve the mental health of the community, 28 percent named a psychiatrist, and three percent named a minister. This contrasts with the Joint Commission's findings and the literature reviewed by Halpert.

The issue of social distance in the psychiatric hospital has received attention. The optimal social distance between personnel and patients is sought (41). Henry described the need for maintaining social distance between the patient and the staff member (42). Schwartz and Schockley stressed that nurses must keep the appropriate distance from patients, both psychologically and physically (43).

Many feel that increased social interaction decreases social distance. It is felt that when the unknown and feared object becomes known and familiar it is a less suitable object for projection and displacement of repressed ego-alien tendencies. Knight, in her study of college teachers and students (44), found a decrease in social distance between them as a result of social interaction. Altrocchi and Eisdorfer (45) found that with students in advanced stages of college and nursing training increased information alone did not result in favorable changes in attitudes. Favorable changes came from training that included contact with the patient and the learning of psychotherapeutic behavior. Chin-Shong, however, wrote that "even if

close contact with the m[illegible] ill should reduce ordinary fear, other objections to them will arise, based on realistic experience . . ." (28). Whatley also found no relation between attitudinal social distance and acquaintance with a mental patient (34).

As was mentioned above, the vanguard of psychiatric opinion is oriented more toward the conclusions of Star, the Cummings, and the Joint Commission about the public's attitudinal social distance than toward the preponderance of contradictory evidence. This has had far-reaching consequences and has pervasively influenced psychiatric opinion. The resistance to policies that have proven beneficial, such as open doors, is rationalized in terms of the community's fears and hostility and its pressure that the mentally ill be isolated. The documented quantitative findings of almost all the studies of the past ten years, however, repeatedly refuted the qualitative concept of a monolithic majority of any community "closing ranks" against the mentally ill.

In this study, we have examined the opinions and attitudes of a blue-collar population toward mental illness. We have compared our results with those of the 1960 Baltimore study (18) for consistency.

Methodology

The Department of Psychiatry of the Johns Hopkins Hospital has been providing comprehensive psychiatric services to United Auto Workers members employed at the General Motors plants in the Baltimore metropolitan area. The cost of these services is paid through a prepaid insurance plan mediated through Blue Cross and Blue Shield. Concomitantly, a research program was undertaken for the ongoing evaluation of this program and its implications for the prepayment of psychiatric services for the working class. We will examine here that part of the initial field survey that dealt with the study population's opinions about mental illness and their attitudinal social distance from the ex-mental hospital patient.

The insured group consisted of 4,827 workers and their families. A probability sample of 1,076 was chosen. Only one member from each household was interviewed. In the case of married members, the spouse was the predesignated respondent in 50 percent of the cases. The sample was representative of a population of 8,000 U.A.W. members and their spouses. A completion rate of 87 percent was achieved (937 respondents).

The sample was a one-class population the upper part of class IV (46). The typical respondent was white, 40 years old, and lived in a row house. He was a high school dropout, was born in Baltimore or lived there for many years, had been married for over 17 years, and had two children; he had worked at the same job for over 13 years and his family income was close to $9,000.

Our questionnaire was developed by extensive testing and was administered by experienced interviewers. It included the five questions that form the basis of this paper; they were the first questions to mention mental illness. No mental health educational efforts were directed at the sample until this field survey was completed.

Discussion of Results

Our first concern was the definition of mental illness as an illness. Respondents were asked: "Do you think people who are mentally ill require a doctor's care just as much as people who have any other sort of illness?" More than 99 percent of the respondents answered yes.

Ten years ago a probability sample of the entire population of Baltimore was questioned. They were given Star's original brief standard descriptions of a withdrawn schizophrenic girl, an alcoholic man, and a paranoid man. These persons were not identified as mentally ill. Respondents were asked "Do you think X should see a doctor or not?" For the schizophrenic girl, 93 percent answered yes. For the paranoid, 96 percent answered yes. For the alcoholic, 85 percent answered yes. Thus two random samples, a decade apart, using different question formats, gave virtually identical responses: both populations studied conceived of the mentally disturbed individual as "ill," in need of medical attention, and, by inference, falling within the sociologically defined "sick role," with all that such a role implies.

The second question dealt with optimism or pessimism about the outcome of treatment. It has been claimed that the public believes that no mentally ill person is ever really "cured" and that a permanent stigma

TABLE 1
Response to Social Distance Questions About the Formerly Mentally Ill (Percentages)

QUESTION	DEFINITELY WILLING	PROBABLY WILLING	PROBABLY UNWILLING	DEFINITELY UNWILLING	DON'T KNOW	TOTAL
How would you feel about working on the same job with someone who had been mentally ill?	49	45	3	2	1	100
How would you feel about rooming with someone who had been mentally ill?	14	50	18	15	3	100
Could you imagine yourself falling in love with someone who had been mentally ill?	15	49	14	13	9	100

is attached to anyone with such an illness (1, 5, 16). To the question "Do you think that most people who are mentally ill can be cured with the proper treatment?" 89 percent of the respondents said yes, five percent said no, and six percent did not know. In the 1960 Baltimore study, using specific case descriptions, 79 percent felt that the paranoid could be cured, 72 percent the schizophrenic, and 57 percent the alcoholic. It would be difficult to infer public pessimism from these responses.

The remainder of the study deals with attitudes toward ex-mental patients, using three social distance statements (7); the results are shown in table 1. Viewing the responses to all three questions, it is evident that more persons are willing to associate with the formerly mentally ill than are unwilling. For example, if a former mental patient were to work among our population of factory workers, he would encounter only two fellow workers out of each 100 who would be definitely unwilling to work with him because he was a former mental patient. When seeking a roommate, only 15 percent would definitely reject him solely on the basis of his psychiatric history. And in courtship only 13 percent would definitely reject him because he was an ex-mental patient. Members of few ethnic or religious groups in the United States encounter such a small degree of rejection.

Another way of interpreting the findings is to make the assumption that respondents who answered "probably willing" or "definitely willing" are really answering "yes" and those who answered "definitely unwilling" or "probably unwilling" are really answering "no." Such an assumption makes possible the classification of respondents into five types: 1) those who could *not* fall in love, room, or even work with someone who had been mentally ill, representing the extreme of rejection; 2) those who would be willing to work with but *not* room with or fall in love with; 3) those who would be willing to work with or room with, but *not* fall in love with; 4) those who answered "yes" to all three questions, representing the extreme of acceptance; and 5) those who gave any other answers. The result of such a classification is shown in table 2. The magnitude by which the most extremely accepting exceed the most extremely rejecting is significant: almost 15 times as many people gave totally accepting responses as gave totally rejecting ones.

Finally, one may examine the degrees of social distance embodied in the three questions and, simultaneously, the extent of willingness to accept such social distance. This is done by assigning a weight to each question and to each response. The responses implying the closest contact receive the highest weight, 3, and those implying the least contact, lowest weight, 1. The response indicating the greatest willingness to

TABLE 2
Patterns of Negative and Affirmative Responses to Three Social Distance Questions

RESPONSE	NUMBER	PERCENT
NO to all three	36	4
YES to Work with; NO to Room with, Fall in love with	124	14
YES to Work with, Room with; NO to Fall in love with	80	9
YES to all three	515	58
All other combinations	133	15
Total	888*	100

* Forty-nine responses were eliminated from this tabulation because the respondents either were or had been clinic patients

TABLE 3

Social Distance Index of U.A.W. Members Toward the Formerly Mentally Ill (N = 888)*

CATEGORY	DEGREE OF CONTACT	DEFINITELY WILLING +2	PROBABLY WILLING +1	DON'T KNOW 0	PROBABLY UNWILLING -1	DEFINITELY UNWILLING -2	DEGREE OF CONTACT
Work with	1	443 (+886)	400 (+400)	9 (0)	27 (-81)	9 (-54)	3
Room with	2	124 (+496)	444 (+888)	27 (0)	160 (-320)	133 (-532)	2
Fall in love with	3	133 (+798)	436 (+1 308)	80 (0)	124 (-124)	115 (-230)	1

* Social distance index = $\frac{3\,435}{888}$ = +3.86

accept social contact receives the highest weight, +2 and the least willingness, the lowest weight, -2. The number of responses in each category is multiplied by the weights for that degree of contact and degree of acceptance. These products are summed and then divided by the total number of people answering; see table 3. The result is a weighted average of social distance for this population—or an index of social distance.[1] By combining both the degree of social distance and the intensity of feeling, the index permits a quantitative comparison of the overall acceptance by any population of the mentally ill.

The total possible range of the social distance index in this study is from a minimum of -12 to a maximum of +12. The mean score, i.e., the index of social distance for the population studied, was +3.86 or about 66 percent of the maximum possible acceptance. The fact that the sign is positive shows that there is more acceptance than rejection. What does this degree of acceptance mean? In the late 1920s Bogardus, the originator of the concept of social distance, asked 1,725 native-born Americans to rank 21 ethnic groups, using questions similar to those used in this study. Computing the index of social distance for these groups shows that the sixth most favorably accepted group was the French. They attained a value of +3.4 on the same score range, or less than that obtained for the mentally ill in this study. By contrast, the Japanese—the lowest ranking group—attained a value of -4.36, i.e., only 30 percent of the possible range of acceptance. The same index of social distance for the 1960 Baltimore study also shows a considerable degree of acceptance (60 percent).

These results should be considered against the general view that psychiatric patients will be the subject of community stigma and rejection. Such predictions by mental health professionals easily lead to errors in planning and distorted communications with public leaders; they might even boomerang into a self-fulfilling prophecy. Paranoid stances are rarely productive of fruitful cooperation.

Summary and Conclusions

The hypothesis tested here was that the preponderance of the public has attitudes toward the mentally ill that are characterized by stereotyping, stigmatization, rejection, and prejudice and regards them as incurable. Our sample was almost unanimous in considering mental illness an illness requiring a physician's care. Social distance questions used in previous studies were employed and the responses were compared for consistency with a 1960 study of the Baltimore area. The questions examined willingness to work with, to live with, or to fall in love with an ex-mental patient. There is evidence that for at least a decade the public has accepted mental illness as illness, that it looks to the medical profession for the treatment of this illness, and that it is optimistic about the outcome of such treatment. There is no evidence in this study of extreme rejection by blue-collar workers of the mentally ill. As mental health professionals, we must move away from assumptions based on studies of two decades ago. The time may have come to write a belated epitaph to the long-vanished "closed ranks."

[1] The rationale and derivation of this social distance index and its application to this and other studies are described in detail elsewhere (47).

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