Americans' Views of Mental Health and Illness at Century's End: Continuity and Change

Public Report on the MacArthur Mental Health Module, 1996 General Social Survey

Bernice A. Pescosolido
Jack K. Martin
Bruce G. Link
Saeko Kikuzawa
Giovani Burgos
Ralph Swindle
Jo Phelan

With the 1996 Mental Health Module Team:

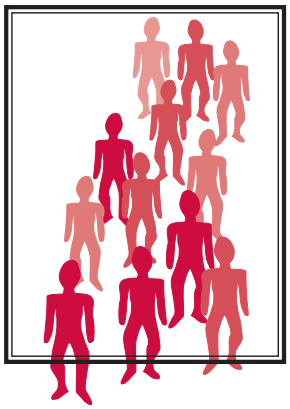
Carol A. Boyer
Michaeline Bresnahan
Jeremy Freese
Kenneth Heller
John Monahan
Brian Powell
Sharon Schwartz
Ann Stueve
Steven A. Tuch
Jason Schnittker

With the technical assistance of:

National Opinion Research Council
Indiana Consortium for Mental Health Services Research
Overseers' Board of the General Social Survey

Funded with support from the MacArthur Foundation, the National Institute of Mental Health, and the National Science Foundation. This report is based on a series of scientific publications, papers, and presentations by the Module Team (Section XI).

For additional copies, please contact:



I N D I A N A
C O N S O R T I U M
for
MENTAL HEALTH
SERVICES RESEARCH

Department of Sociology
Ballantine Hall 771
Indiana University
Bloomington, IN 47405
tel. (812) 855 3841
fax (812) 856 5713
pescosol@indiana.edu

Report Issued By:
The Indiana Consortium of Mental Health Services Research, Indiana University
and
The Joseph P. Mailman School of Public Health, Columbia University

Americans' Views of Mental Health and Illness at Century's End: Continuity and Change

Table of Contents

I. Introduction and Purpose

The public's attitudes toward those with mental health problems comprise the larger social context in which individuals and their families experience these problems. This social and cultural atmosphere sets the tone for public reaction to persons with mental health problems and toward proposed policy initiatives to assist them. The classic studies of Americans' knowledge of and attitudes toward persons with mental illness and substance abuse problems began in the 1950's with Shirley Star's first national survey and was continued, in spirit, in the two large national studies, *Americans View Their Mental Health* (1957, 1976). Since that time much has changed in terms of scientific study, treatment, and policy. Until now, the question remained about the impact of these important changes on the attitudes, beliefs and opinions of the American people. This report is based on papers (listed in Appendix XI) that have emerged from the MacArthur Mental Health Module of the 1996 General Social Survey and on supplementary analyses conducted specifically for this report. The papers and this report provide answers to basic questions about where the public stands. In particular, this report addresses the following questions:

- How knowledgeable are Americans about mental illness and substance abuse problems? Can they recognize these problems? What do they think about the benefits of treatment?
- What are the public's beliefs about the underlying causes of these problems? How much have they come to adopt medical explanations? Does the public hold onto beliefs about the roles of child-rearing, character flaws and divine intervention?
- How do Americans assess the competence of persons with mental health problems? Their dangerousness?
- How willing are Americans to have day-to-day interactions with persons with mental health problems at home? On the job? In their neighborhood?
- What does the American public think are appropriate actions that persons with mental illness or substance abuse problems should take? How willing are they to allow the use of legal means to force treatment?
- Who does the American public believe to be responsible for the cost of care in these cases? The person? The family? Insurance? Charity? The government?

II. Executive Summary

The Issues: The last fifty years have witnessed dramatic changes in our understanding of mental illness and substance abuse – from scientific knowledge about causes, to the shift from treatment in long-term care facilities (or "asylums") to community-based care with short, periodic hospitalization. Yet, relatively little scientific effort has been focused on understanding how the general public has changed in their attitudes, beliefs and behaviors toward their own and others' mental health problems. These issues of labels, the public responses to cause and treatment, their willingness to have social contact, and their opinions on who should shoulder responsibility for costs represent the larger, community context which individuals, their families, medical care providers and policy makers face. The information provided here, from a nationwide study of Americans, provides updated and detailed information on community context so that policy makers, community leaders, families and consumers can more effectively address the challenges ahead.

The 1996 Study: The major questions that will affect the success of the current experiment to treat mental illness, in general, and the deinstitutionalization of those with severe mental illness, in particular, guide our effort:

- What is mental illness?
- How do people become mentally ill?
- What are mentally ill people like?
- What can be done to help mentally ill people and who should be responsible?

The results here not only provide a broad description of the current state, but where possible, we mark changes over the last forty years in the United States. Many of the questions are asked with reference to a vignette provided to the respondent. These scenarios, while not labeled as such for the respondent, represented individuals meeting criteria for schizophrenia, major depression, alcohol dependence, and drug dependence. An additional vignette described a person with problems of daily living which did not meet criteria for any DSM-IV diagnosis (see Technical Appendix A).

Methodology

- The primary data utilized in this study are the1996 General Social Survey (GSS), the 1976 and 1957 Americans View Their Mental Health Surveys (AVTMH), and the 1950 Dilemmas of Mental Illness Survey (DMIS).
- All data analyzed in this report were obtained via personal interviews with nationally representative samples of noninstitutionalized adults living in the contiguous United States.
- Completed interviews were obtained from 1,444 respondents in the 1996 GSS, 2,464 respondents in the 1976 AVTMH, 2,460 respondents in the 1957 AVTMH, and 3,531 respondents in the 1950 DMIS.
- Sample estimates for the 1996 GSS have a margin of error of +/- 2.6%, for the 1976 and 1957 AVTMH the sampling margin of error is +/- 2%, for the 1950 DMIS the sampling margin of error is +/- 5.2%.
- 1996 GSS Respondents were administered the MacArthur Mental Health Module, a 57- item interview schedule of questions focused on knowledge, attitudes and beliefs about the causes, consequences, and treatment of mental health problems.

Findings*

(* Superscripts refer to the scientific paper on which statements are based. See list in Section XI. Other findings are based on additional analyses done for this report.)

- In the 1950s, when asked the meaning of mental illness, the largest proportion of the American public mentioned behaviors indicative of either psychoses or anxiety/ depression. When asked this same question in 1996, however, large numbers of Americans broadened their definitions of mental illness to also include less severe psychological problems such as mild anxiety and mood disorders.[1]
- When asked to distinguish between what constitutes a "nervous breakdown" and a "mental illness", in the public mind a nervous breakdown corresponds most closely to neurotic and mood disorders whereas a mental illness designates serious psychotic and social deviant behaviors.[2]
- In 1996 relatively large numbers of Americans have first-hand knowledge of persons suffering from

mental health problems, with over half of all Americans reporting personally knowing someone who had been hospitalized due to a mental illness. An even larger percentage of the public also reports knowing others who have received outpatient mental health services.

- When asked to characterize the severity of the problem encountered by persons experiencing depression, schizophrenia, alcohol dependence, and drug dependence, the vast majority of the public views these conditions as representing "very serious" problems.
- Between 1950 and 1996, the proportion of Americans who describe mental illness in terms consistent with violent or dangerous behavior nearly doubled.[1]
- The vast majority of the American public believes that persons suffering from depression, schizophrenia, alcohol dependence, and drug dependence are likely to represent a threat for violence toward self. Similarly, with the exception of depression, the public also believes that those experiencing mental health problems pose a threat for violence toward others.[3,4]
- Regardless of the type of mental disorder considered, women are seen as significantly less likely to pose a threat for dangerous or violent behavior.[5]
- When asked to assess the ability of persons suffering from a mental health problem to manage finances or make treatment decisions, a majority of Americans believe that persons suffering from depression are competent to make these decisions. Only a minority of the public, however, believes that persons experiencing schizophrenia, alcohol dependence, or drug dependence are capable of making these decisions.[4]
- In 1957, 1 of 5 Americans reported having personal fears of an impending "nervous breakdown". By 1996 this number had increased significantly with nearly 1 in 3 Americans reporting similar fears.[2]
- Persons in 1996 most likely to have anticipated an impending "nervous breakdown" are women, whites, unmarried, younger, without children, have lower income, are less educated, and are without a religious affiliation.[2]
- Perceptions of events believed to induce a nervous breakdown have changed over the last forty years. In particular, in 1996 personal health problems are mentioned less frequently as precipitating events, and events affecting loved ones are mentioned more frequently than in either 1957 or 1976.[2]
- When asked what they did when faced with an impending nervous breakdown, the most common response was to seek formal help. This pattern has remained relatively unchanged over the 40-year interval.[2]
- Between 1957 and 1996 the percentage of the American public who indicated that they would seek informal support to deal with an anticipated nervous breakdown increased over 400 percent.[2]
- Compared to their counterparts in 1957 and 1976, Americans today are significantly more likely to rely on prescription medications and mental health professionals when faced with an anticipated psychological problem. They are also much less likely to turn to a physician for help with these problems.[2]
- In 1996 the American public is particularly inclined to endorse the use of prescription medications for the treatment of depression and schizophrenia.
- Overwhelmingly, the American public believes that if treated, mental health problems will improve. They also believe, however, that if left untreated, these problems will not improve on their own.
- Americans see the utility of a wide variety of potential sources of help for those suffering from mental health problems, but when asked to indicate whom they would turn to first, the majority indicated they would seek help from family and friends.
- Americans are nearly uniform in their belief that legal means should be used if needed to force the hospitalization of mentally ill persons who represent a threat to themselves or others.[4]
- Without regard to perceived level of threat, the public is most willing to use the force of law to ensure the mental health treatment of those suffering from schizophrenia, and in particular, those who are drug dependent.[4]
- Large numbers of the American public assign primary responsibility for the costs of mental health treatment to the affected individual and private insurance companies. If necessary, these individuals assign secondary responsibility to the families of those with mental health problems.[6]
- Nearly half of all Americans feel that the government should be spending more on mental health services, even if this additional spending requires new taxes. Only 1 in 10 Americans would prefer to see the government spend less on these services.[6]
- Over two-thirds of the American public believe that the government "definitely" or "probably" has the responsibility to provide mental health services to those with psychological problems.[6]
- There is little evidence that the stigma of mental illness has been reduced in contemporary American society. Preference for social distance in most social

settings between the public and those with mental health problems remains distressingly high.[7]
- Without regard to the type of mental health problem considered, the public is least willing to accept persons suffering from psychological problems as family members or coworkers.[7]

Overview

The goal of this study is to examine the public's perceptions of mental illness and substance abuse, and to determine how individuals with these mental health problems recognize and seek help. In particular, we seek to understand how these views may have changed over time and whether stigma is still a major problem. Furthermore, we ask what people believe are the causes of mental illness and substance abuse, what can be done for persons with these problems, and their comfort level with persons who are mentally ill. Finally, we address concerns about costs of care, legal issues in involuntary treatment, and who should be responsible for individuals with mental health problems. We see this work as speaking to the interests of mental health advocates, policymakers, and professionals.

A major challenge to mental health and substance abuse policy is the repeated demonstration in epidemiological studies that more than two thirds of individuals experiencing diagnosable mental health problems do not seek professional care. It is thought that lack of knowledge about mental illness, the stigma of mental illness, and ignorance about effective treatments play an important role in lack of treatment-seeking. Compounding this problem is a mismatch of professional's preference for working with the "worried well" and the compelling unmet needs for community- based treatment for the deinstitutionalized severely mentally ill. The original *Americans View Their Mental Health* study by Gerald Gurin, Joseph Veroff, and Sheila Feld supported an emphasis on national education about mental illness that was incorporated in the original 1960's and 70's Community Mental Health legislation. In the 1980's and 1990's, consumer groups added their voices and family stories in a call for stepped-up community support treatment programs, the search for new medications and a better understanding of the biology of mental illness, and the destigmatization of mental illness. These have been positive moves aimed at destigmatizing severe mental illness and matching treatment resources to the needs of the severely mentally ill and their families.

Possibly countering these positive trends, however, have been rare but highly visible acts of violence by mentally ill persons such as the Son of Sam murders, the assassination of John Lennon, assassination attempts on Presidents Ford and Reagan, and on George Harrison, and the Unabomber's terrorist campaign. There has been the epidemic of crack-related murders in the 90's. Rural America has been struck by an unprecedented rash of church arsons. School shooting rampages by students are threatening to turn schools into fortified enclaves. Finally, popular films such as *Taxi Driver, Swingblade, Son of Sam*, and *Psycho* (twice) epitomize an entertainment media that capitalizes on the rare but sensational, with widespread but unknown impacts on the public's views of mental illness.

In the twenty years that have passed since the AVTMH was replicated, much has changed in mental health care: a dismantling of national mental health legislation in the 1980's; the development of new medications and therapeutic approaches; and the advent of a primary care-mental health carve-out system of health care. We have little idea how the historical literature on stigma and labeling now applies in current public conceptions. Much too has changed in the methodology of assessment.

In 1950, Shirley Star collected the first major survey on mental illness at NORC, at the University of Chicago. While the results were never formally published and the final report never written, both the methodological and substantive findings of this work have been highly influential. In the mid-1950's Gerald Gurin, Joseph Veroff, and Sheila Feld fielded *Americans View Their Mental Health*. This survey, entitled "Study of Modern Living," asked about several domains of life (work, marriage, physical and mental health), the problems that individuals faced, and how they responded. In 1976, the *AVMH* was replicated. Our current understandings of these issues make some of their methodological approaches out-of-date (in part because of the advances they made and future directions they suggested).[1] We used two new strategies. Rather than ask a diffuse, general question (e.g., How likely are persons with depression to hurt themselves?), we presented our sample of Americans with a case or vignette describing a person who, according to the criteria in the *Diagnostic and Statistical Manual-*

[1] We thank Tom Smith and Patrick Bova at NORC for their assistance and advice on retrieving the original Star survey forms, and Toni Antonnucci, Elizabeth Douvan and Joe Veroff for the same on the AVMH studies.

IV, met criteria for either schizophrenia, major depression, alcohol dependence, or drug dependence. These cases were largely the inspiration of the Module team members from the Columbia University School of Public Health. Second, we found a core of items in each survey that would allow us to mark changes in the public's understanding, experiences of and responses to mental health problems and issues over a forty year period (see Technical Appendix). Public knowledge, attitudes and beliefs shape personal and policy decisions that have tremendous bearing on the quality of life of people who suffer from mental illness. A comparison over time facilitates our understanding of the changing public understanding of and response to mental illness, both in personal ways and in the way that they think about and support public policy change. These ideas, background work (including meeting with original researchers), and comparable coding were developed by the Module team members associated with the Indiana Consortium for Mental Health Services Research. The issues and questions on competence, dangerousness, and coercion were inspired by the work of the MacArthur Law and Mental Health Network.

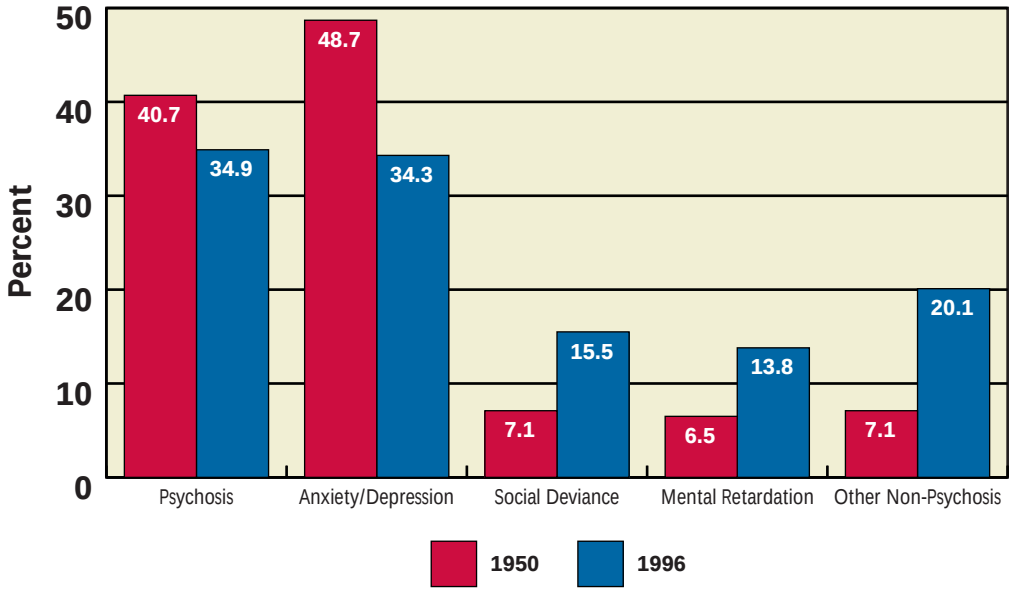
III. Americans' Recognition of Mental Health Problems in 1996: Continuity and Change since the 1950s.

As noted, the last fifty years have witnessed dramatic changes in the public's perceptions and understanding of mental illness. One anticipated result of these changes is a presumed broadening of the public's definition of just what constitutes a mental health problem. In other words, it has been suggested that in defining mental health problems, contemporary Americans will be more likely to include less severe problems such as mild anxiety and mood disorders in that definition than were their counterparts five decades earlier. In order to assess this possibility, the 1996 GSS included an open-ended question identical to that asked by Shirley Star in 1950: "Of course, everyone hears a good deal about physical illness and disease, but now, what about the ones we call mental or nervous illness…When you hear someone say that a person is mentally ill, what does that mean to you?" Responses to this item in 1950 and 1996 are summarized in Figure 1.

In 1950, when asked the meaning of mental illness, the largest proportion of respondents mentioned behaviors indicative of either psychoses (reported by 40.7%) or anxiety/depression (reported by 48.7%), with very low percentages mentioning social deviance (7.1%), mental retardation (6.5%), or other non-psychotic disorders (7.1%). These reports, however, have changed dramatically in the 1996 data. While it remains in 1996 that the largest percentage of respondents continue to mention behaviors consistent with psychoses (34.9%) or anxiety/depression (34.3%), such reports are sharply reduced from the earlier 1950 levels.

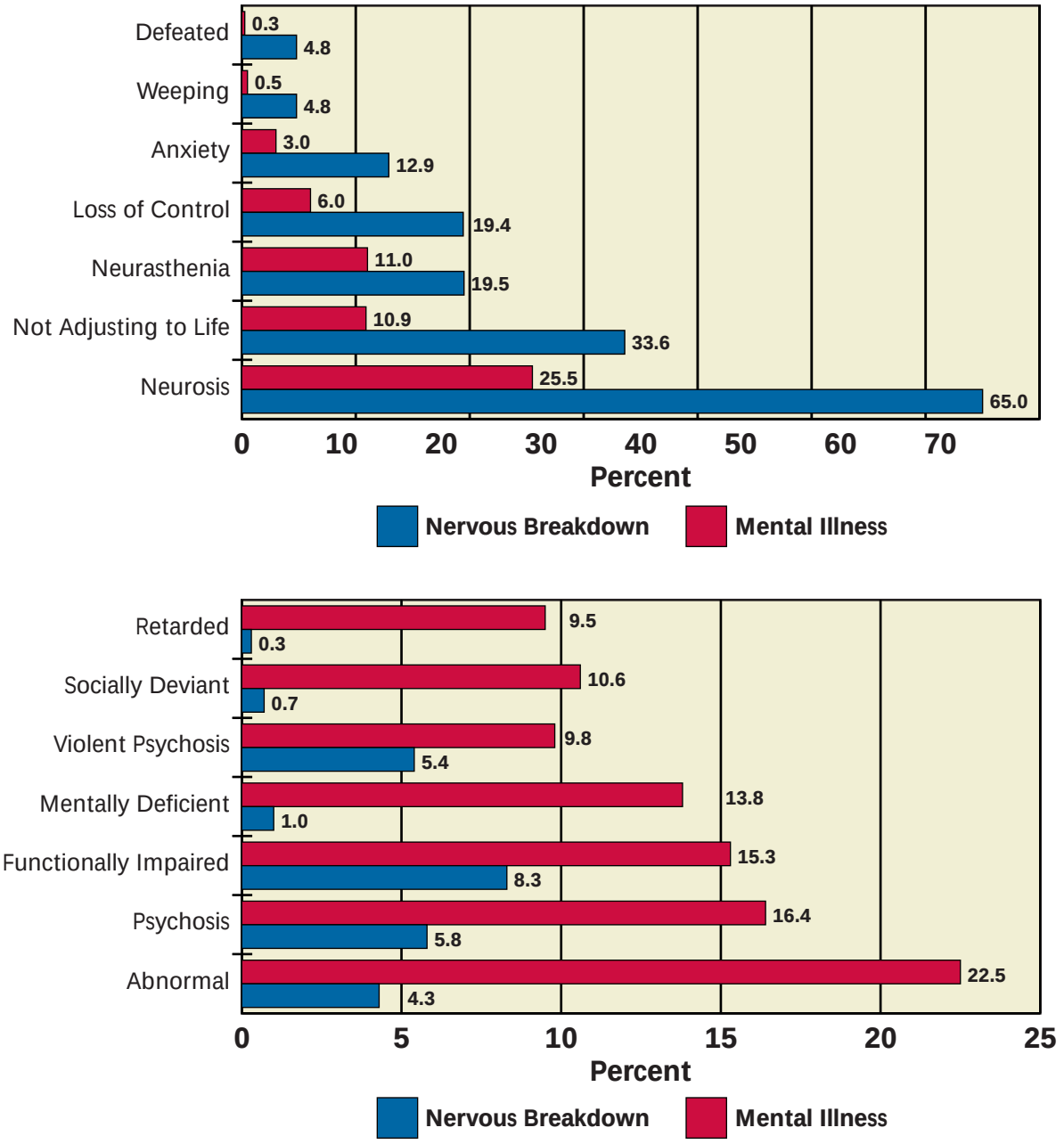
By contrast, the percentage of respondents whose descriptions of mental illness included references to anti-social or deviant behavior and mental retardation more than doubled from 1950 to 1996. This pattern is even more pronounced in the case of descriptions of mental illness that reference non-psychotic disor-

Figure 1. Classification of Americans' Responses to "What is Mental Illness"



Adapted from: Phelan, J.C., B.G. Link, A. Stueve, and B.A. Pescosolido. 2000. "Public Conceptions of Mental Illness in 1950 and 1996: What is Mental Illness and is it to be Feared?" *Journal of Health and Social Behavior,* 41(2).

Figure 2. Percentage of Americans Mentioning Symptoms for Nervous Breakdown and Mental Illness



Adapted from: R. Swindle, K. Heller, B.A. Pescosolido, and S. Kikuzawa, 2000. "Responses to Nervous Breakdowns in America Over a 40-year Period: Mental Health Policy Implications." *American Psychologist,* 55(7).

ders, where the percentage of respondents defining these conditions as mental illness nearly tripled to 20.1% (up from 7.1% in 1950). Thus, while large numbers of Americans continue to view mental illness in more-or-less conventional terms (i.e., as psychotic or anxious/depressed behavior), over the last five decades it would appear that public definitions of what constitutes a mental health problem have indeed broadened.

Another topic not adequately addressed in previous research, but a key issue for the 1996 GSS researchers, was the public's understanding of the meaning of the term "nervous breakdown" as compared to other concepts such as "mental illness". In order to examine this distinction, half of the 1996 respondents were asked to describe the characteristics of a mentally ill person, and the other half to describe a nervous breakdown. A comparison of responses to these two items is displayed in Figure 2.

Examination of the data in Figure 2 indicates that in the public mind a "nervous breakdown" corresponds most closely to neurotic and mood disorders. Commonly employed descriptors for a person who suffered a "nervous breakdown" included neurosis (mentioned by 65%), being unable to adjust to life (mentioned by 33.6%), neurasthenia (mentioned by 19.5%), loss of control (mentioned by 19.4%) and anxiety (mentioned by 12.9%). A somewhat different picture emerges when examining how respondents described a person suffering from "mental illness". Here public perceptions are more likely to highlight more serious psychotic disorders and socially deviant behavior. For example, common descriptors included abnormal/disordered behavior (mentioned by 22.5%), psychosis (mentioned by 16.4%), functional impairment (mentioned by 15.3%), mental deficiencies (mentioned by 13.8%), social deviance (mentioned by 10.6%), violent psychosis (mentioned by 9.8%) and mental retardation (mentioned by 9.5%). It is also appropriate to note that three descriptors commonly used to characterize a "nervous breakdown" were also mentioned by a non-trivial percentage of the respondents who were asked to describe "mental illness". Specifically, when asked to describe "mental illness" 25% of respondents mentioned symptoms consistent with neurosis, 11% mentioned neurasthenia symptoms, and 10.9% mentioned adjustment problems.[1,2]

The 1996 data, then, provide some evidence for a broadening of the public's definition of what constitutes a mental illness. These data show, however, that the American public's definition of mental illness increasingly includes violence or other "frightening" characteristics. Table 1 provides data highlighting this trend. For example, in 1950 7.2% of Americans spontaneously described mental illness with terms referencing violent, dangerous, or frightening behavior. Over the fifty-year interval, however, the use of these terms had markedly increased. For example, in 1996 the proportion of respondents using terms indicative of violent or dangerous behavior to describe mental illness had increased significantly, nearly doubling to 12.1% (up from 7.2% in 1950). Similarly, the proportion of Americans describing mental illness in terms consistent with a diagnosis of violent psychosis also increased noticeably, up from 6.8% in 1950 to 12.4% in 1996. Thus, it would appear that while the American public has enlarged their definition of mental illness to include less severe problems such as mild anxiety and mood disorders, this broadening has also been accompanied by a somewhat contradictory increase in the public's perception that persons suffering from mental illness are likely to represent a threat for violent or dangerous behavior.[1]

In addition to examining past and present conceptions of mental illness, we agreed that it was important to determine whether or not Americans based their perceptions, at least in part, on first-hand knowledge or personal interactions with persons suffering from mental health problems. To assess this question,

Table 1. American's Perception of Violence as Part of Mental Illness

Responses to What Is Mental Illness	Star 1950 %	GSS 1996 %
Violent, Dangerous, Frightening	**7.20**	**12.10**
Describes Violent Psychosis	**6.80**	**12.40**

Adapted from: Phelan, J.C., B.G. Link, A. Stueve, and B.A. Pescosolido. 2000 . "Public Conceptions of Mental Illness in 1950 and 1996: What is Mental Illness and is it to be Feared?" *Journal of Health and Social Behavior,* 41(2): 188-207.

the 1996 GSS asked respondents if they had ever known anyone hospitalized for a mental illness and their relationship to the hospitalized individual, and whether they had ever known anyone else (other than the hospitalized person) who was seeing a psychologist, mental health professional, social worker, or counselor. Responses to these items, summarized in Table 2, indicate that half (50.2%) of all Americans report having known someone who had been hospitalized due to a mental illness, with roughly a quarter of respondents indicating that the hospitalized person was a member of their immediate family, another relative, or a close friend. Moreover, an even larger percentage of respondents (57.9%) also reported knowing yet another person(s) who had received mental health services outside of a hospital setting. These data would suggest, then, that relatively large numbers of Americans today have at least some first-hand knowledge of persons suffering from mental health problems.

Table 2. Nature of Respondents' Contact with Persons with Mental Health Problems

Nature of Contact	% Yes	(N)
Knows Someone who was in a Hospital because of a Mental Illness	**50.2**	**(729)**
Who was it?		**(364)**
Respondent	**2.5**	
Immediate Family	**25.3**	
Other Relative	**27.2**	
Close Friend	**26.9**	
Acquaintances	**24.2**	
Other	**7.1**	
Knows Other Seeing a Psychologist, Mental Health Professional Social Worker, or Counselor	**57.9**	**(670)**

IV. Public Perceptions of the Causes, Labels and Severity of Mental Illness and Substance Abuse

What does the American public believe are the root causes of mental illness? Are Americans more likely to invoke biological, personal, or spiritual explanations when asked to account for the genesis of mental health problems? Does the public endorse different causal attributions for different types of mental health problems? Prior to the 1996 GSS, there had not been a large, national research effort to find answers to these obviously important questions.

In an attempt to shed much needed light on these and other important questions regarding public perceptions of mental illness, a team of investigators from Columbia University developed an experiment including vignettes and questions about vignettes, and brought to the drafting meetings for the 1996 Mental Health module. From the vignettes they submitted, four were selected by the Module members: Schizophrenia, Major Depression, Alcohol Dependence, and Troubled Person. To these four a fifth was added to depict Cocaine Dependence. The questions about the vignettes were modified, improved and expanded by the module team. The history of and rationale for using vignettes to study public conceptions of mental illness is provided in Link et al. (1999). The mental health problems described in the vignettes were selected on the basis of severity, prevalence, and potential consequences of

Table 3. Percentage of Americans' Reporting on the Nature of the Problem in the Vignette

	Vignette Story				
Respondent Report	**Alcohol Dependence %**	**Depression %**	**Schizophrenia %**	**Drug Dependence %**	**Troubled Person %**
Ups and Downs of Life	**62.0**	**79.6**	**40.0**	**40.8**	**96.2**
Nervous Breakdowns	**52.9**	**69.6**	**83.9**	**43.2**	**20.9**
Mental Illness	**48.6**	**69.1**	**88.2**	**43.5**	**21.5**
Physical Illness	**57.5**	**67.5**	**48.2**	**52.2**	**36.1**
Alcohol Abuse	**97.7**	**—**	**—**	**—**	**—**
Depression	**—**	**94.6**	**—**	**—**	**—**
Schizophrenia	**—**	**—**	**84.8**	**—**	**—**
Drug Abuse	**—**	**—**	**—**	**96.7**	**—**

Adapted from: Link, B.G., J.C. Phelan, M. Bresnahan, A. Stueve, B.A. Pescosolido. 1999. "Public Conceptions of Mental Illness: Labels, Causes, Dangerousness, and Social Distance." *American Journal of Public Health* 89(9): 1328-1333.

Table 4. Americans' Report of the Severity of the Vignette

Vignette Story	Severity				
	Very Serious	Somewhat Serious	Not Very Serious	Not Serious at All	(N)
Alcohol Dependence	77.5	21.0	1.4	0.0	(276)
Depression	53.6	40.0	5.8	7.0	(295)
Schizophrenia	79.2	17.1	2.4	1.4	(293)
Drug Dependence	97.9	2.1	0.0	0.0	(289)
Troubled Person	4.5	28.5	44.9	22.1	(267)

misidentification. After hearing one of the five vignette persons described, respondents were asked a series of inter-related questions that sought to assess whether or not the person described had a mental illness, how serious the person's problem is, the probable cause of the problem, etc.[3]

Turning first to how respondents defined the nature of the problem experienced by the person described in their vignette, Table 3 reports the percentage of respondents who indicated that the specific problem experienced was "very likely", or "somewhat likely" to be due to the normal "ups and downs" of life, a nervous breakdown, a mental illness, a physical illness, and the specific DSM-IV diagnostic disorder. According to these data, the vast majority of respondents correctly classified the specific disorder described in their vignette. For example, 97.8% of respondents hearing the depression vignette correctly indicated that the person was experiencing a major depression. Similar patterns were obtained for schizophrenia (84.8% of respondents were correct), alcohol dependence (with 97.8% correct), and drug dependence (96.7% correct).[3]

The data in Table 3 point to several additional patterns of note. To begin, a clear majority of respondents (62%) feel that it is likely that persons experiencing alcohol dependence do so as part of the of the normal ups and downs of life, with an even higher percentage (79.6%) indicating that depression can be seen as the result of this same process. As might be expected, large majorities also believe that persons suffering from depression or schizophrenia are experiencing a nervous breakdown (69.6% and 83.9%, respectively), or a mental illness (69.1% and 88.1%, respectively). Finally, it is interesting to note that over half of respondents believe that alcohol dependent, drug dependent, and depressed persons are experiencing a type of physical illness.

While the data indicate that large numbers of Americans utilize multiple definitions for the types of problems they believe are being experienced by the vignette person, respondents are more- or-less uniform in their perceptions regarding the severity of these problems. Data relative to this issue are reported in Table 4. When asked to characterize the severity of the specific problem experienced by the person described in the vignette, for each of the four mental health problems a clear majority indicated the problem was "very serious". As might be expected, respondents were nearly unanimous in describing drug dependence as representing a very serious problem (97.9%), but it is interesting to note that over three-quarters of respondents indicated that schizophrenia (79.2%) and alcohol dependence (77.5%) are also very serious problems. Only in the case of the vignette describing a person experiencing major depression was the percentage of respondents answering "very serious" reduced somewhat, with 53.6% characterizing depression as a very serious problem. It should be pointed out, however, that in the case of depression an additional 40% of respondents viewed this condition as being at least "somewhat serious", with only 6.5% indicating that depression was "not very" or "not at all" serious. Indeed, when the "very serious" and "somewhat serious"

responses are combined, for each of the four mental health problems well over 90% of respondents define these conditions as representing serious problems.

It would appear, then, that Americans are nearly uniform in their assessments of the severity of the problems experienced by persons with various forms of mental illness. There is far less uniformity, however, in how the public views the root causes of these problems. In Table 5 we turn our attention to this issue. In this table we ask, "Are contemporary attributions for the sources of mental health problems based primarily on genetic/medical, social structural, or individual-level causes?"

According to the data in Table 5, drug dependence is the only disorder for which the respondents' attribute an individual-level source – bad character (reported by 31.5% of respondents). For schizophrenia, on the other hand, chemical/biological attributions predominate, with nearly half of all respondents (46.9%) very likely to attribute the source of this disorder to a chemical imbalance. For depression and alcohol dependence, respondents tend to invoke social structural attributions (i.e., stress) as causal mechanisms. Indeed, a majority (54.5%) of respondents attribute depression and nearly 4 of 10 (36%) attribute alcohol dependency to problems related to dealing with daily stressors.[7]

Table 5: Americans' Attributions Modal Category for Specific Mental Health Problems, Percentage Responding "Very Likely" to the Underlying Cause of the Problem (Panel 1), and Percentage Responding "Very Likely" that the Problem is a Mental Illness (Panel 2).

Panel 1:	Depression %	Schizophrenia %	Drug Dependence %	Alcohol Dependence %	Troubles %
Chemical	20.8	46.9	20.8	16.2	4.8
Genetic	13.3	20.7	5.7	12.3	5.2
Stress	54.5	33.8	25.5	36.0	38.0
Way Raised	11.5	8.2	10.7	11.1	13.2
Bad Character	11.2	14.1	31.5	20.2	9.0
God's Will	6.8	6.0	2.1	1.9	8.0
Panel 2:					
"Very Likely" Mental Illness	20.4	54.4	13.3	10.3	1.4

Source: Martin, J.K., B.A. Pescosolido, and S.A. Tuch. 2000. "Of Fear and Loathing: The Role of 'Disturbing Behavior', Labels, and Causal Attributions in Shaping Public Attitudes Toward Persons With Mental Illness." *Journal of Health and Social Behavior*, 41(2): 208-233. Also see Link, B.G., J.C. Phelan, M. Bresnahan, A. Stueve, and B.A. Pescosolido. 1999. "Public Conceptions of Mental Illness: Labels, Causes, Dangerousness, and Social Distance." *American Journal of Public Health* 89(9): 1328-1333.

The data displayed in Table 5 also indicate that with the exception of depression, there is no clear consensus regarding the source of drug dependence, alcohol dependence, or schizophrenia. For example, over one-fifth of respondents (20.8%) report chemical imbalance as a cause of drug dependence, while another quarter (25.5%) mention stress. One-fifth of respondents (20.2%) see bad character as the underlying cause of alcohol dependence. Regarding the sources of schizophrenia, one-third of respondents (33.8%) point to stress, and an additional fifth (20.7%) identify genetic factors as the causal mechanism. Finally, it is interesting to note that only a small minority of respondents are likely to attribute the source of any of the four mental health problems as "God's will".[7]

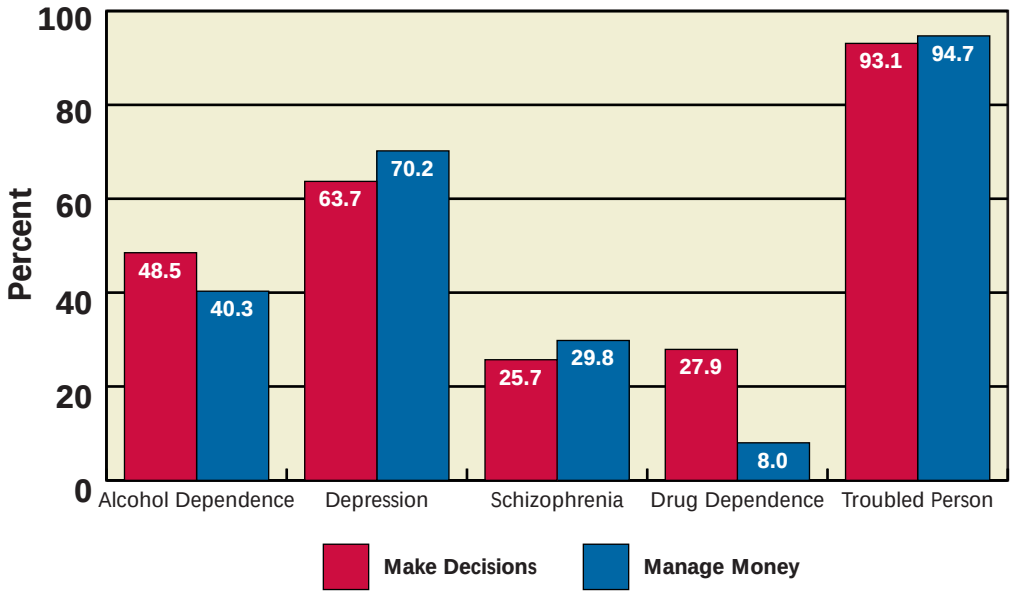
V. Public Views of Competence and Dangerousness of Persons With Mental Health Problems.[4]

How do Americans assess the abilities of persons with mental health problems, and what threats do these individuals pose to society? In an attempt to provide answers to these questions, the 1996 GSS interview included two items tapping public perceptions of the competence of those suffering from mental health problems to manage treatment decisions and personal finances. An additional two items sought to assess the perceived level of threat for violence to self and others posed by persons with mental health problems. Responses to these items are summarized in Figures 3 & 4.

Figure 3 presents the percentage of respondents who indicated that the person described in their particular vignette was "very" or "somewhat able" to make treatment decisions (red bars) and to manage finances (blue bars). Examination of these data reveals several interesting patterns. To begin, as expected, nearly all respondents see the person described in the reference category (i.e., the person with subthreshold "troubles"), to be competent to manage decisions regarding either treatment (93.1%) or finances (94.7%). Similarly, when asked to assess the competence of persons suffering from major depression, a majority of respondents indicate that a person with depression is either "very" or "somewhat able" to make decisions regarding treatment (63.7%) and money management (70.2%).

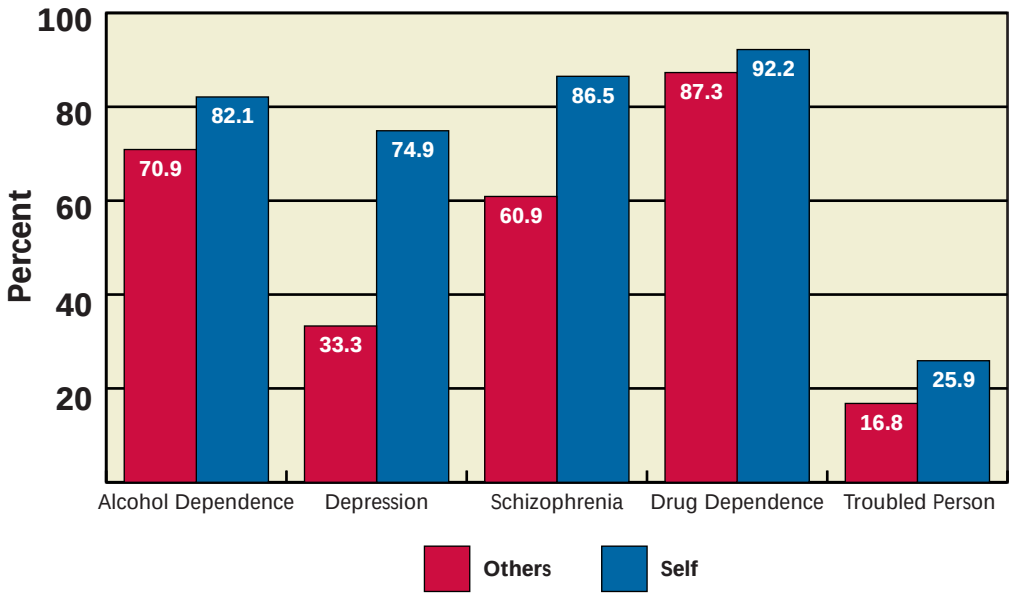
On the other hand, persons described as suffering from alcohol dependence, schizophrenia, and drug dependence are viewed as significantly less competent to manage decisions in either domain. In the

Figure 3. Percentage of Americans Reporting Vignette Person as Very or Somewhat Able to make Treatment Decisions or to Manage Money



Adapted from: Pescosolido, B.A., J. Monahan, B.G. Link, A. Stueve, and S. Kikuzawa. 1999. "The Public's View of the Competence, Dangerousness, and Need for Legal Coercion Among Persons with Mental Health Problems." *American Journal of Public Health* 89(9): 1339-1345.

Figure 4. Percentage of Americans Reporting Vignette Person as Likely to do Something Violent to Others or Self



Adapted from: Pescosolido, B.A., J. Monahan, B.G. Link, A. Stueve, and S. Kikuzawa. 1999. "The Public's View of the Competence, Dangerousness, and Need for Legal Coercion Among Persons with Mental Health Problems." *American Journal of Public Health* 89(9): 1339-1345.

case of alcohol dependence, for example, only a minority of respondents feel that the vignette person is at least "somewhat able" to make competent decisions regarding treatment (48.5%) or finances (40.3%). Moreover, this pattern is significantly more pronounced for persons described as suffering from schizophrenia or drug dependence. When the person described in the vignette presents symptoms consistent with a diagnosis of schizophrenia, only slightly more than a quarter of respondents (25.7%) believe that person to be competent to make decisions regarding treatment issues, and only 29.8% indicate that a person suffering from schizophrenia is competent to make financial decisions. Respondents' levels of skepticism, however, are highest when asked to rate the competence of those who are drug dependent. In this case, only 27.9% of respondents believe a drug dependent individual can make appropriate decisions regarding treatment, and less than 1 in 10 feel that a person with a drug habit is "somewhat" or "very able" to make competent decisions with regard to financial matters. Further, in a multivariate analysis of the correlates of perceptions of competence (data not shown)[4], assessments of the vignette person's competence did not vary as a function of the vignette person's individual attributes (i.e., age, education, ethnicity, or gender). In other words, regardless of the background characteristics of the person described as suffering from a specific mental health problem, it was the mental health problem alone that was predictive of the consistent public perception of reduced decision-making ability.[4]

Earlier we reported data to suggest that over the last fifty years the American public has become more likely to equate mental illness with a potential for violent or dangerous behavior. In Figure 4 we examine this finding in more detail by specifying a referent (i.e., violence toward self or others). According to the data displayed in Figure 4, Americans discriminate among the different mental health problems with respect to potential for dangerous behavior. Respondents perceive the highest potential for violent behavior among those who are either drug or alcohol dependent. For persons described as drug dependent, 92.2% of respondents report that person to be "very" or "somewhat likely to do violence to self, and 87.3% feel that a drug dependent person is likely to do violence to others. This pattern is somewhat reduced for those who are described as alcohol dependent, but it remains that over 8 of 10 respondents see the alcohol dependent individual as likely to do violence to self, and over 7 of 10 see this person as at least "somewhat likely" to do violence to others.[3,4]

When the vignette person is described as suffering from symptoms consistent with a diagnosis of schizophrenia, public perceptions of dangerousness to self are somewhat lower when compared to descriptions of individuals suffering from substance dependency. Nonetheless, over 6 of 10 respondents (60.9%) perceive a potential for violence toward others among individuals suffering from schizophrenia, and nearly 9 of 10 (86.5%) believe that individual is likely to commit violence toward him/herself. The proportion remains essentially unchanged for the depression scenario for the likelihood of violence toward self (74.9% believe the depressed individual is likely to do something violent toward him/herself), but changes dramatically when dangerousness toward others is considered. In this case, only a minority (33.3%) believes that the individual described as experiencing major depression would likely do violence toward others.[3,4]

The data reported in Figure 4, then, are clear. With regard to public perceptions of dangerousness, the vast majority of respondents believe that persons suffering from mental health problems represent a threat for violence toward themselves. Similarly, with the exception of persons suffering from depression, the public also believes that those experiencing mental health problems pose a threat for violence toward others. Finally, it should also be pointed out that in a multivariate analysis of the correlates of perceived dangerousness (data not shown), the race, ethnicity, and education of the person described in the vignette were not predictive of the public's perceptions of danger. Gender, on the other hand, did emerge as an important correlate. Regardless of the type of mental disorder considered, respondents were significantly less likely to indicate a potential for dangerous or violent behavior if the person in the vignette was identified as a woman.[5]

VI. Americans' Personal Mental Health Problems: Responses to "Nervous Breakdowns" in the 1950s, 1970s, and 1990s.

In 1957 and 1976, researchers at the University of Michigan conducted two landmark studies of Americans' views of, and responses to, mental health problems. These studies, the *Americans View Their Mental Health* (AVTMH) surveys, provided important benchmarks for national mental health policy. Much, however, has changed in the ways in which the public views mental health problems and in the American mental health care system itself since the last AVTMH survey. Thus, the 1996 GSS survey provided the opportunity to determine how strategies for dealing with a mental health problem may have changed over the last 40 years.

Replicating a series of items from the earlier AVTMH surveys, the 1996 GSS researchers sought to examine how Americans' view their personal risk for developing a mental health problem, their beliefs regarding the precipitants of these problems, and their strategies for dealing with a mental health problem, should one occur. Specifically, the GSS researchers sought to answer three inter-related questions: 1) Is the American public more likely to admit feeling they were going to have a mental health problem today than in previous generations?; 2) Have perceptions of the precipitants of mental health problems changed over the last 40 years?; and 3) Are there any differences in how Americans today would deal with a mental health problem as compared to previous decades?

In both the 1957 and 1976 AVTMH surveys respondents were asked, "Have you ever felt that you were going to have a nervous breakdown?". This question was repeated in the 1996 GSS interview. Responses to this question across the three surveys are reported in Table 6. According to these data, in 1957 nearly 1 in 5 Americans (18.9%) reported having felt an impending nervous breakdown at some time in their lives. This proportion had increased somewhat over the 20-year interval between 1957 and 1976, such that in the 1976 AVTMH survey, 20.9% of Americans reported that at some point they felt as though they were nearing a nervous breakdown. The largest and most significant increase in the percentage of Americans indicating that they had feared an impending nervous

Table 6. Percentage of Americans Responding that They had Anticipated a "Nervous Breakdown"

	Have you ever felt you were going to have a nervous breakdown		
	1957 %	1976 %	1996 %
Raw/Crude Prevalence	**18.9**	**20.9**	**26.4**
Adjusted Prevalence	**17.0**	**19.6**	**24.3**

* In addition, 5.3% in 1996 responded "no" to nervous breakdown but "yes" to a follow-up question about having mental health problems.

Adapted from: Swindle, R., K. Heller, B.A. Pescosolido, and S. Kikuzawa. 2000. "Responses to 'Nervous Breakdowns' in America Over a 40-year Period: Mental Health Policy Implications." *American Psychologist*, 55(7).

breakdown, however, occurred between 1976 and 1996. By 1996, more than 1 in 4 Americans reported that at some time they have been concerned that they were close to a nervous breakdown. It is also important to note that the significant increase in the number of Americans who endorse feeling they were about to have a nervous breakdown is not an artifact of changes in the demographic profile of the American public over the last 40 years. Adjustments for demographic factors yield adjusted prevalence rates that are attenuated somewhat, but that nonetheless point to the same steady and significant 40 year increase in reports of an anticipated nervous breakdown observed in the crude prevalence rates.[2]

In order to ensure that individuals who might reject or not understand the somewhat outmoded term "nervous breakdown" were also included in these analyses, respondents in 1996 who responded "no" to the nervous breakdown question were asked the follow-up question, "Have you ever had a mental health problem?". An additional 5.3% of the GSS respondents reported that they have had a mental health problem at some point in their life. Thus, when those who reported having felt like they were going to have a nervous breakdown are combined with those who admitted to having had a mental health problem, nearly a third of all Americans (31.7%) in 1996 indicate they have personally anticipated or experienced a problem related to their mental health.[2]

In an attempt to identify those factors related to the likelihood of having anticipated a mental health problem, a multivariate analysis of the combined 1957, 1976 and 1996 surveys was conducted. According to this analysis (data not shown), women, whites, unmarried persons, younger individuals, those without children, individuals who have not attained a high school education, persons reporting low family income, and those who do not report a religious affiliation/ identification are significantly more likely to report having feared an impending mental health problem.[2]

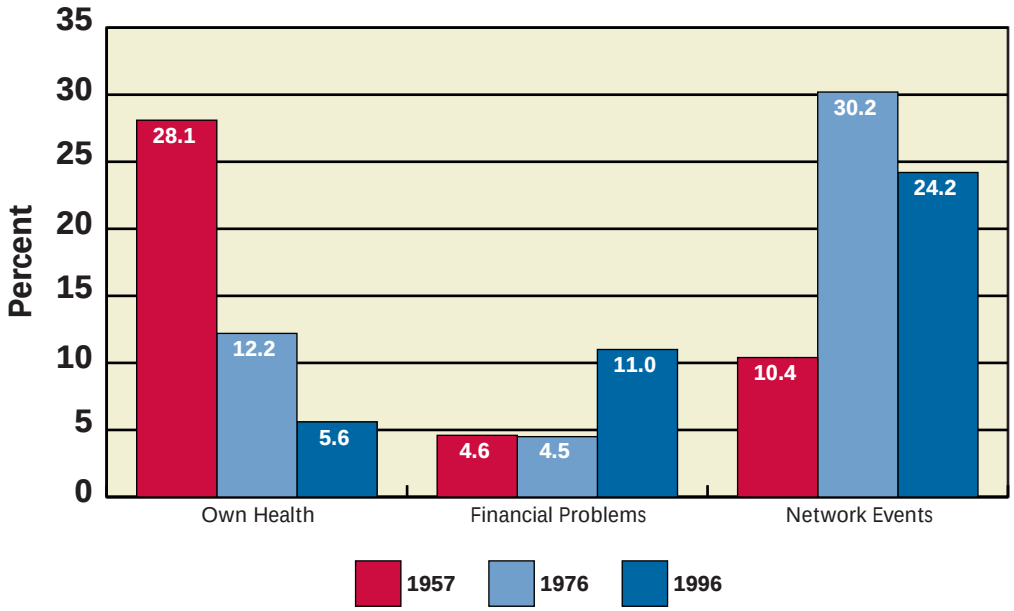
In order to gain a more nuanced understanding of the correlates and consequences of an anticipated

Table 7. Percentage of Americans Responding that They had a "Nervous Breakdown" or Mental Health Problems

Timing	Nervous Breakdown (N = 288) %	Mental Health Problems (N = 61) %
Present	5.9[1]	21.3[3]
Past Only (nothing given)	26.7	26.2
Past - More Than 5 Years	33.3	31.1
Past - Less Than 5 Years	34.0	21.3
Duration		
Long-Term	50.2[2]	54.2[4]
Short-Term	19.4	6.3
Don't Know	30.3	39.6

[1] Does not include 99 people who reported nervous breakdown but did not indicate timing.
[2] Does not include 176 people who reported nervous breakdown but did not indicate duration.
[3] Does not include 28 people who reported mental health problems but did not indicate timing.
[4] Does not include 41 people who reported mental health problems but did not indicate duration.

Figure 5. Selected Reasons for Anticipated Nervous Breakdown, 1975 (N=327), 1976 (N=441) 1996 (N=356)



Source: Swindle, R., K. Heller, B.A. Pescosolido, and S. Kikuzawa. 2000. "Responses to 'Nervous Breakdowns' on America Over a 40-year Period: Mental Health Policy Implications." *American Psychologist,* 55(7).

mental health problem, all respondents who indicated that they have had fears of an impending nervous breakdown or reported they had experienced a mental health problem were asked a series of follow-up questions. For example, these respondents were asked when they had these fears/problems and how long these feelings/problems lasted. Responses to these questions are summarized in Table 7.

Examination of the data in Table 7 indicates that only a minority of respondents currently anticipate a nervous breakdown or experience a mental health problem. Specifically, among those who have feared an impending nervous breakdown, only 5.9% indicate that they are now concerned with this possibility. Respondents reporting having had a mental health problem, on the other hand, are four times more likely (21.3%) than those who anticipated a nervous breakdown to indicate that they now experience problems with respect to their mental health. This difference notwithstanding, the vast majority of respondents who have either experienced a mental health problem or have anticipated a nervous breakdown, did so in the past.

Responses are also consistent with regard to the duration of mental health problems or concerns. Of those respondents who were able to recall the duration of their mental health problem, a majority (50.2% of those who had anticipated a nervous breakdown and 54.2% of those who reported having a mental health problem) also indicated that these were long term events. It is interesting to note, however, that respondents who have anticipated a nervous breakdown are more likely to indicate that this was a short-term process than are their counterparts who have experienced an actual mental health problem (19.4% vs. 6.3%, respectively).

In addition to timing and duration, individuals who endorsed feeling like they were going to have a nervous breakdown were asked to identify what they felt were precipitating events. Moreover, since this question was asked in each of the three surveys, we are able to examine responses to this item over time. These data are summarized in Figure 5. These data indicate that over the last 40 years, Americans who have felt they were going to have a nervous breakdown also demonstrated some significant shifts in their perceptions of precipitating events. Most notably, the percentage of respondents who pointed to personal health problems as the reason for fearing a nervous breakdown declined markedly across the study interval. In 1957 health problems were mentioned as the reason for anticipating a nervous breakdown by over a quarter of respondents (28.1%). This

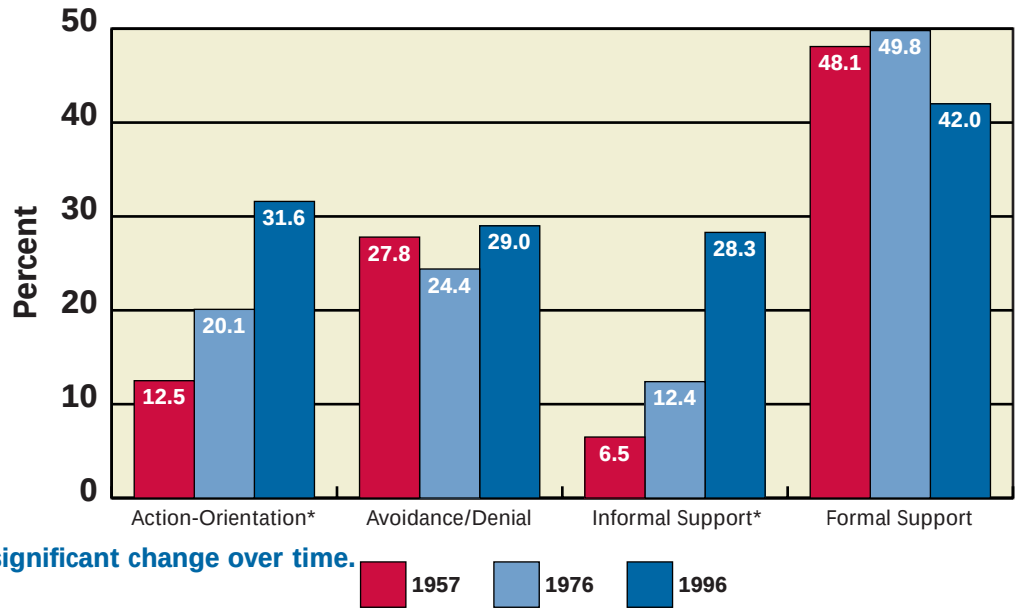
proportion was down to 12.2% in the 1976 AVTMH data, and fell yet again to a nominal 5.6% in the 1996 GSS survey.

Other noteworthy trends regarding commonly mentioned precipitants for anticipation of a nervous breakdown are seen in the role of financial problems and network events. Changes in network events (i.e., events affecting loved ones) increased significantly between 1957 and 1976 (mentioned by 10.4 of eligible respondents in 1957 and 30.2% in 1976), and remained highly salient in 1996. In 1996 the most frequently cited network events related to an anticipated nervous breakdown were divorce, marital strains, marital separation, and troubles with members of the opposite sex. Similarly, financial problems (i.e., low income or loss of income), remained stable at about 4% between 1957 and 1976, but were mentioned by 11% of eligible respondents in 1996. Other commonly cited reasons for anticipating a breakdown (i.e., work/school problems, problems with other's health, and housing problems) remained more-or-less stable across the study interval. Of these three additional precipitants, only work/school problems (reported by about 17% of eligible respondents in 1976 and 1996) were mentioned by more than a very small percentage of those who had ever anticipated a nervous breakdown (data not shown).[2]

In all three survey years, persons who had anticipated an impending nervous breakdown were asked what they did when they felt this way. Answers to this question provided insights into continuity and change in American's preferred coping and helpseeking behaviors when faced with a mental health problem. Responses to this question fell into four broad categories: 1) approach/action oriented coping (i.e., use of logical analysis, positive reappraisal, problem solving, etc.); 2) avoidance/denial coping (i.e., seeking alternative rewards, emotional discharge, doing nothing, etc.); 3) seeking informal support (i.e., seeking help from family, friends, self-help groups, etc.); and 4) seeking formal support (i.e., seeking help from physicians, psychiatrists, mental health specialists, etc.). The data in Figure 6 displays the percentage of respondents mentioning these four categories of coping response across the three surveys.[2]

Examination of the trend data indicates that there were two major changes in Americans' responses to an anticipated nervous breakdown: an increase in approach/action-oriented coping, and an increased

Figure 6. Percentage of Americans Responding to Nervous Breakdown with Action-Orientation, Denial/Avoidance, Seeking Informal Support, and Formal Support



*** Indicates significant change over time.**

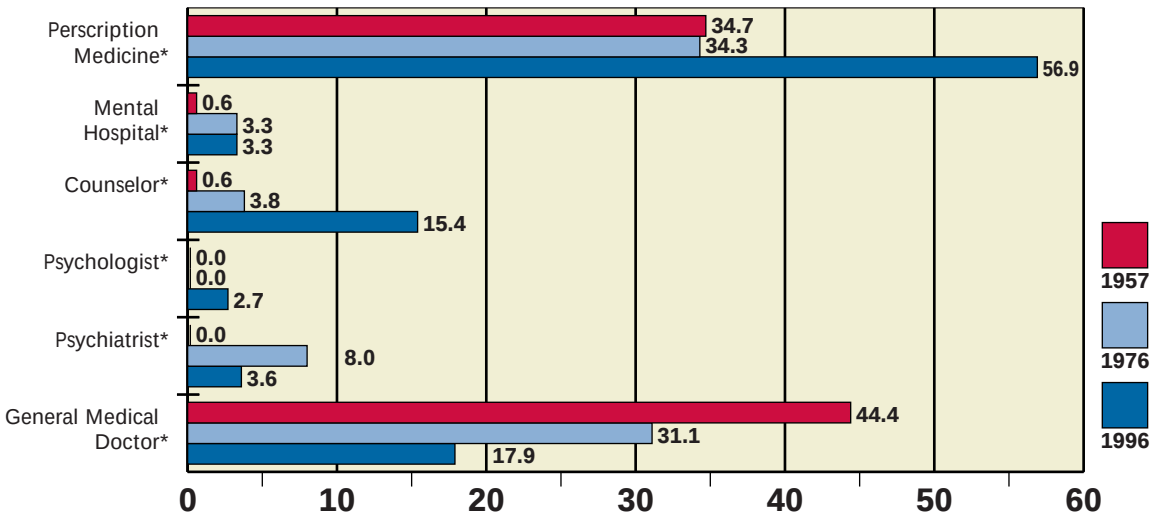
Adapted from: Swindle, R., K. Heller, B.A. Pescosolido, and S. Kikuzawa. 2000. "Responses to 'Nervous Breakdowns' on America Over a 40-year Period: Mental Health Policy Implications." *American Psychologist,* 55(7).

reliance on informal social supports. In 1996, 31.6% of respondents endorsed action-oriented coping strategies, up significantly from the 1957 level of only 12.5%, and the 20.1% level reported in the 1976 survey. Similarly, turning to informal supports such as family and friends showed a strong increase over the last 40 years. In 1957 only 6.5% of those who had feared an impending nervous breakdown indicated that they would turn to informal support networks to cope with this problem. By 1996, however, this percentage had grown to over 28 percent, an increase of 400% over 1957 levels, and 200% over 1976 levels.[2]

With regard to the public's willingness to utilize avoidance/denial-oriented coping or to seek formal sources of support, responses are more-or-less consistent across the study interval. There is evidence, however, that Americans are somewhat less likely to seek formal help in 1996 than in previous years. Moreover, as indicated in Figure 7, within the various categories of formal support there have been several dramatic changes. For example, the percentage of respondents who indicated that they would seek help from a physician for a nervous breakdown declined dramatically, falling to only 17.9% in the 1996 survey. On the other hand, the willingness to seek help from counselors, social workers, and mental health professionals increased markedly across the study interval, up from less than 1% in 1957 to over 15% of respondents in 1996. It is also interesting to note that in 1996, Americans are significantly more likely to report that they would turn to prescription medications in an attempt to deal with an anticipated mental health problem. Indeed, a majority of respondents in 1996 (i.e., 56.9%) reported that they would rely on medications to mitigate potential psychological problems.[2]

In a related analysis of the 1996 data a series of multivariate models were estimated to determine if respondents matched coping responses to particular causes of mental health problems. According to these analyses (data not shown), approach/action-oriented coping strategies were endorsed most frequently when the respondent identified financial, job, and social network problems. Formal help seeking occurred most often in an attempt to cope with divorce, separation, widowhood, and problems related to personal health, and was significantly less likely to occur when faced with financial, job, or educational difficulties. Avoidance/denial- oriented coping was found to be significantly less likely when the respondent was faced with a health-related problem. Finally, the willingness to turn to informal sources of social support was not found to vary across categories of problems.[2]

Figure 7. Percentage of Americans Use of Selected Sources of Formal Support for Nervous Breakdown in 1965, 1976, and 1996



*** Indicates significant change over time.**

Adapted from: Swindle, R., K. Heller, B.A. Pescosolido, and S. Kikuzawa. 2000. "Responses to 'Nervous Breakdowns' on America Over a 40-year Period: Mental Health Policy Implications." *American Psychologist,* 55(7).

VII. Public Views on the Treatment of Mental Health Problems

Several questions in the 1996 GSS study sought to document general public sentiment regarding the prognosis for persons suffering from mental health problems. For example, all GSS respondents were asked whether the psychological problem experienced by the person described in their particular vignette would likely improve if no action were taken (i.e., would the problem improve "on its own"), and whether the problem would improve if treated. Figure 8 displays the pattern of responses to these items.

Regardless of the particular mental health problem considered, the vast majority think it unlikely that the problem will "spontaneously remit", or improve on its own. Indeed, only 27.5% of respondents believe that the problem is either "very likely" or "somewhat likely" to improve on its own. The remaining 70.1% of respondents are pessimistic, with the largest percentage (46.7%) suggesting that it is "very unlikely" that the vignette person's problem will improve if left alone. This pessimism, however, does not carry over to those situations where the vignette person receives treatment for her/his problem. In fact, public sentiment is overwhelmingly optimistic when asked if the psychological problems described in the vignettes are responsive to treatment. The largest percentage of respondents (48.4%) believe that it is "very likely" that the mental health problems described will improve if treated, with an additional 41.4% indicating that improvement with treatment is at least "somewhat likely".

As illustrated in Figure 9, the public's belief in the effectiveness of mental health treatment is further demonstrated in their responses to each of the individual vignette stories. Indeed, according to these data, respondents were nearly unanimous in the opin-

Figure 8. Percentage of Americans Reporting on Outcomes of Vignette Story

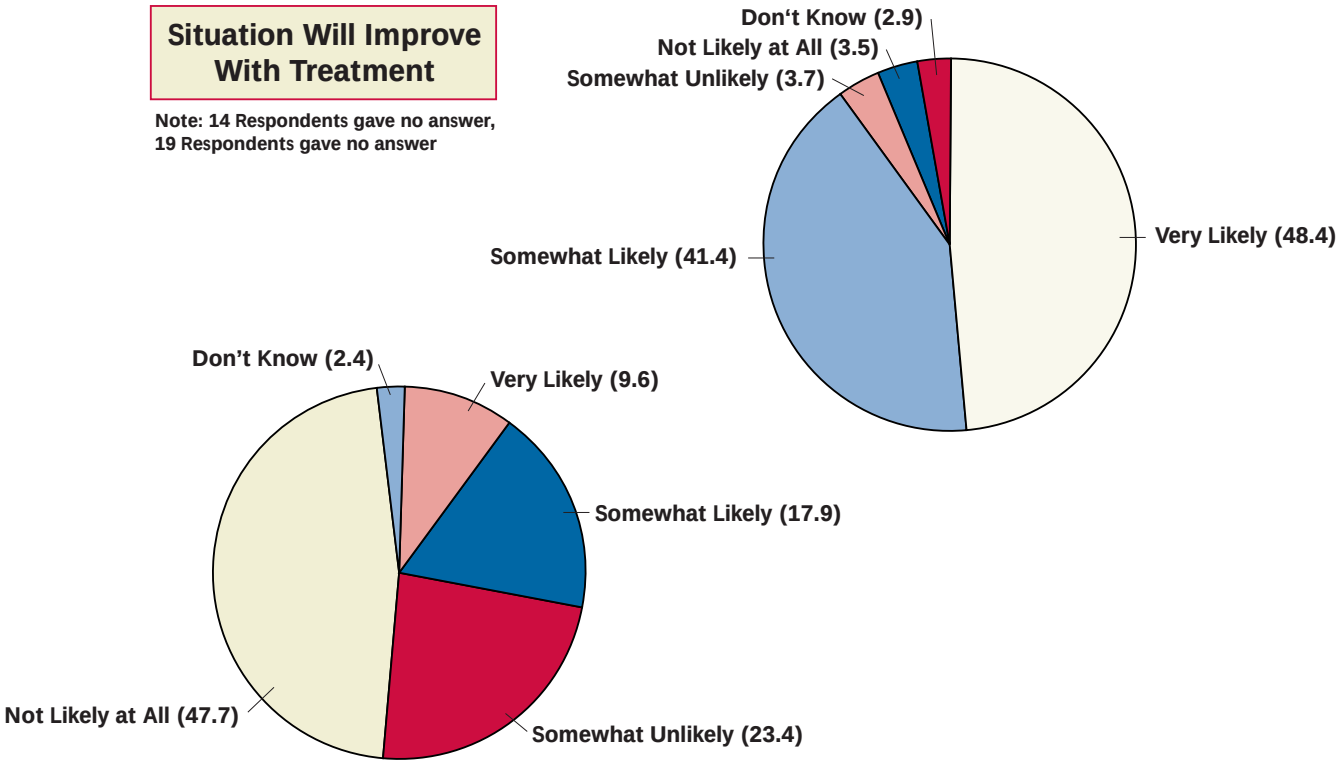
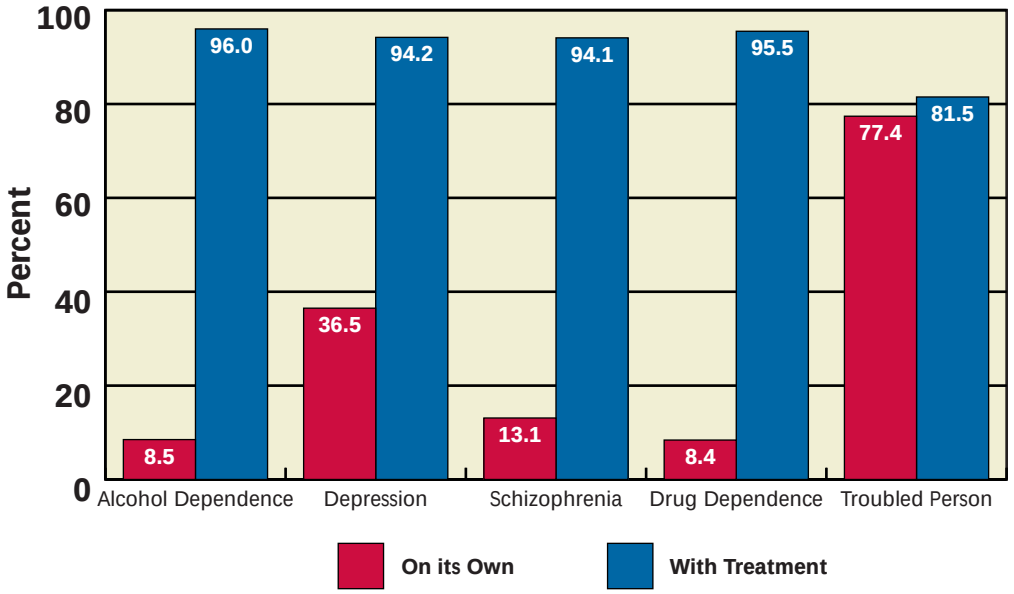


Figure 9. Percentage of Americans Reporting on Whether the Situation will Improve on its own or with Treatment by Vignette Story



ion that the specific mental health disorder described in the vignette was either "very likely" or "somewhat likely" to improve with treatment. Also as before, only a small minority of respondents felt that these problems would likely improve "on their own". This pessimism was particularly pronounced with regard to problems of alcohol and drug dependency, and schizophrenia. Only about 8% believe that drug or alcohol dependency will improve without treatment, and only 13.1% of respondents feel that schizophrenia is likely to remit. It is important to note, however, that a much larger percentage of respondents (36.5%) believe that a person experiencing major depression is likely to improve without any special effort to ameliorate the condition.

Knowing that most Americans believe in the effectiveness of treatment for mental health problems, while an important finding, leads to the question of where the public feels these individuals should seek help for these problems when they arise. In an attempt to shed light on this question, all GSS respondents were asked about ten potential sources for help and whether they felt that the vignette person should turn to these individuals or organizations for assistance or treatment in order to deal with their specific problem. Moreover, respondents were asked to provide a rank order for these potential sources of help. Responses to this series of questions are detailed in Tables 8 and 9, and Figure 10.

Turning first to the public's overall assessment of potential sources for help with mental health problems, the data in Table 8 suggest that without regard to the particular mental health problem being considered, large majorities (i.e., over two-thirds of respondents) suggest seeking help from family and friends (95.3%), self-help groups (83.8%), clergy (83.1%), mental health therapists or counselors (82.6%), physicians (71.9%), or psychiatrists (67.7%). A smaller majority (55.9%) feels that prescription medication would also provide a potential source of help. Three potential sources of help emerge as not being viewed as particularly useful: Only 31.3% of respondents feel that the vignette person should "check into a mental hospital", 20.8% recommend going to spiritual or natural "healer", and only 7.8% suggest taking non-prescription drugs like over-the-counter sleeping pills.

It would appear that Americans see the utility of a wide variety of potential sources of help for those suffering from mental health problems. An important related question, however, is whether the public views certain of these resources as being more useful than others depending on the specific disorder considered. Data relative to this possibility are displayed in Figure 10. In this figure we consider whether the public believes that physicians, psychiatrists, prescription medications, non-prescription medications, and hospitalization are helpful strategies for each of the four DSM-IV disorders described in the individual vignettes. Several notable patterns are evidenced in

Table 8. Percentage of Americans Reporting on Suggestions for Sources of Help*

Sources of Help	% Saying Vignette Person Should Use
Family and Friends	95.3
Minister, Priest Rabbi, or Other Religious Leader	83.1
General Medical Doctor	71.9
Who was it?	
Psychiatrist	67.7
Therapist/Counselor	82.6
Spiritual or Natural Healer	20.8
Self-Help Group	83.8
Non-Prescription Medicines	7.8
Prescription Medicines	55.9
Mental Hospital	31.3

* N's vary slightly due to non-response (N=1,409 to 1,422)

these data. First, the public uniformly endorses seeking the help of physicians and psychiatrists when the vignette person is described as suffering from any of the four psychological disorders. Note also that when the vignette describes a person suffering from schizophrenia, 91.6% of respondents endorse seeking help from a psychiatrist. Second, while relatively large percentages of respondents (i.e., over 40%) endorse the use of prescription medications for each of the specific disorders, they are particularly inclined to recommend this strategy for persons experiencing a major depression (endorsed by 74.7%) or schizophrenia (endorsed by 83.4%). Third, as seen in Table 8, few respondents see the utility of non- prescription medications as effective techniques for dealing with mental health problems. Finally, the data in Figure 10 suggest that overall, Americans are disinclined to recommend that the person suffering from the vignette disorder should "check into a mental hospital". There is, however, one exception to this pattern. When the person in the vignette is described as suffering from schizophrenia, a majority of respondents (61.6%) would recommend hospitalization.

While the data in Table 8 and Figure 10 suggest that the American public is willing to recommend a variety of different potential sources of help for persons with mental health problems, a somewhat different picture emerges when they are asked to indicate which of these options would be their first choice. These preferences are summarized in Table 9. Here the data are quite clear. The most popular help seeking option is going to family and friends (preferred by nearly 51% of all respondents). Of the nine remaining potential sources of help, none are mentioned as being a first choice by other than very small percentages of respondents, with only two being the first preferences of more than 10% of those polled (i.e., physicians

Figure 10. Percentage of Americans Endorsing Sources of Help by Vignette Story

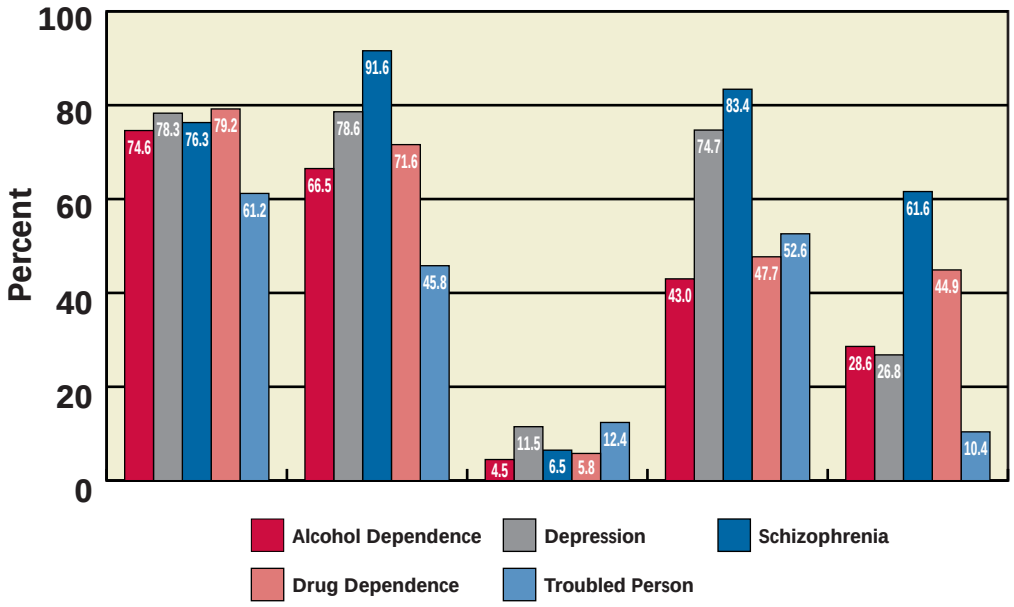


Table 9. Percentage of Americans Giving Sources of Help as Their First Choice

Sources of Help	% Mention as Their First Choice	(N)
Family and Friends	50.9	(1,377)
Minister, Priest Rabbi, or Other Religious Leader	9.0	(1,205)
General Medical Doctor	16.9	(1,046)
Psychiatrist	7.6	(990)
Therapist/Counselor	10.4	(1,198)
Spiritual or Natural Healer	1.2	(327)
Self-Help Group	6.6	(1,215)
Non-Prescription Medicine	2.8	(142)
Prescription Medicines	0.2	(822)
Mental Hospital	6.5	(476)

Table 10. Distribution of Public Views of the Need for Coercion Into Treatment by Mental Health Problems, 1996 General Social Survey

Yes, force by Law to ...	Mental Health Vignette				
	Alcohol Dependence %	Major Depression %	Schizophrenia %	Drug Dependence %	Troubled Person %
Visit clinic or doctor	39.3	21.6	49.1	67.3	6.7
Take prescription medication	24.5	24.3	42.1	36.8	9.7
Admit to hospital	40.7	24.3	44.5	65.8	10.1
Admit to hospital if dangerous to self	87.9	91.5	90.5	94.0	78.1
Admit to hospital if dangerous to others	93.4	94.4	94.8	95.5	82.8

Source: Pescosolido, B.A., J. Monahan, B.G. Link, A. Stueve, and S. Kikuzawa. 1999. "The Public's View of the Competence, Dangerousness, and Need for Legal Coercion Among Persons With Mental Health Problems." *American Journal of Public Health* 89(9): 1339-1345.

were the first choice of 16.9% of respondents, and mental health therapists or counselors were the first choice of 10.4%).

Implicit in the discussion of public sentiment with respect to sources of help for persons with mental health problems is the somewhat contentious notion that when faced with these problems, individuals will be competent to make autonomous effective treatment decisions Of course, some mental health professionals claim that serious mental disorder almost invariably impairs decision-making sufficiently to consider people with mental disorder legally incompetent to make such decisions. The question arises, then, as to whether the American public believes that persons suffering from mental health problems who choose not to seek help should be forced by the state into the mental health treatment system. To assess this obviously important question the 1996 GSS interview included five items tapping whether or not the respondent felt that the person described in the vignette should be forced by law to obtain treatment for their disorder. Responses to these items are summarized in Table 10.

Table 10 presents the vignette specific distribution of "yes" responses toward the use of the law to coerce individuals into seeking medical providers, using medications, and being hospitalized. What is immediately obvious from these data is that Americans are almost uniform in agreement with the need for legal coercion when dangerousness to self or others becomes an issue. Indeed, even for the "troubled person", 78.1% and 82.8%, respectively, agree with the use of legal means if he/she is viewed as dangerous to self or others. Not surprisingly, the public is also somewhat more likely to condone coercion if others, rather than the vignette person herself/himself, are at risk. Also

obvious in these data is a clear discrimination among the public regarding coercion depending on the particular mental health problem described. For example, slightly less than one-quarter of respondents (21.6% for physicians and 24.3% for medication or hospitalization) are willing to use coercion for individuals suffering from depression. On the other hand, nearly half of respondents (42.1% for medication, 44.5% for hospitalization, and 49.1% for physicians) agree that legal means should be used to force those suffering from schizophrenia into treatment.[4]

A somewhat more complex picture emerges with regard to the public's responses to drug and alcohol treatment. Here the willingness to use legal means depends largely on the type of treatment suggested. To begin, respondents are not inclined to force medication for individuals with substance dependency (24.5% for alcohol and 36.8% for drug dependency). Second, only about 40% of respondents are willing to invoke legal means for physician visits or hospitalization in the case of alcohol dependency, but are significantly more willing to do so for drug dependency. Fully two-thirds of respondents indicate that coercion is justified to force drug dependent individuals to see physicians (67.3%) or to be hospitalized (65.8%). Indeed, the data in Table 10 are clear in suggesting that the American public responds most negatively to those suffering from drug dependence. This finding receives additional support when we sum each respondent's positive answers to the five coercion items (data not shown). On average, respondents are willing to use coercion 2.5 times of five for depression, 2.8 times for alcohol dependence, 3.1 times for schizophrenia, and 3.5 times in the case of drug dependence.

VIII. Who is Responsible for Mental Health Care Costs?

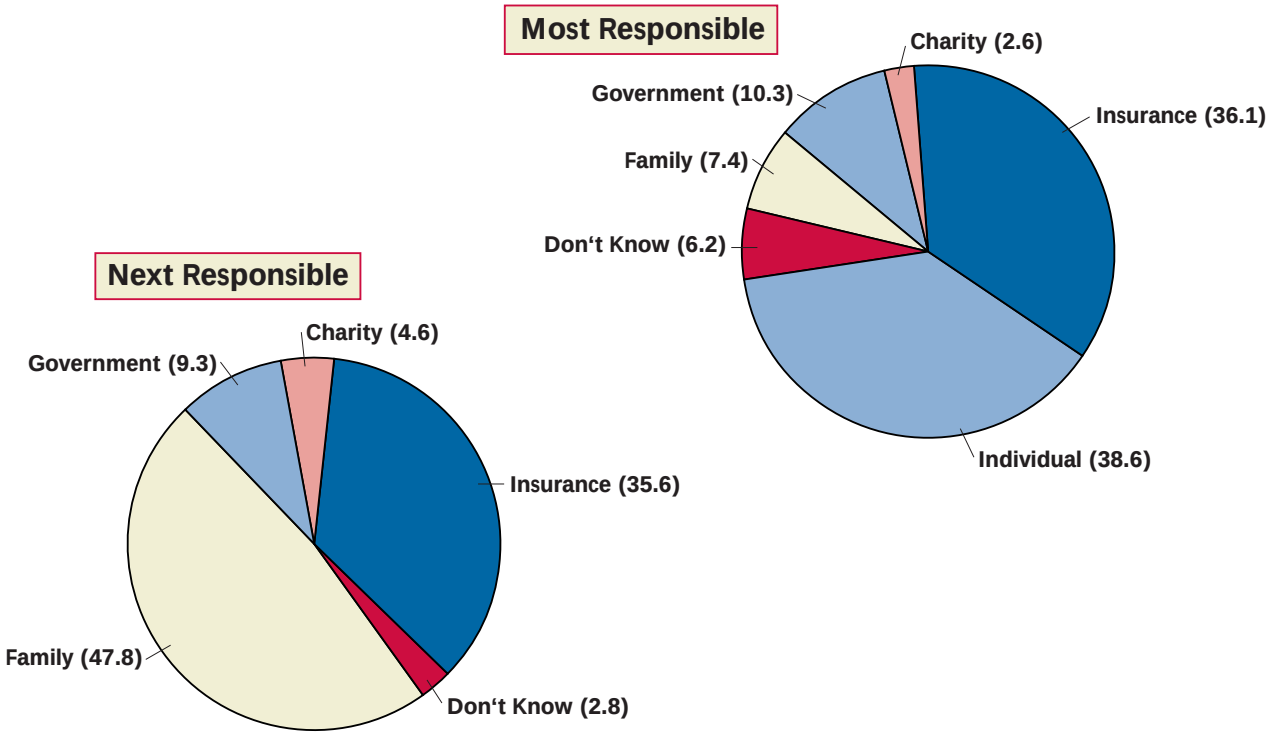
Four items in the 1966 GSS interview asked respondents for their opinions on issues relative to responsibility for the costs associated with the delivery of mental health services. Figures 11 and 12 display the distribution of responses on these items.

All GSS respondents were asked who they felt should have primary and secondary responsibility (i.e., the affected individual, the government, private insurance companies, etc.) for paying for the care needed by the person described in the vignettes. With regard to primary responsibility, respondents were more-or-less equally divided between assigning culpability to the affected individual (38.6%) and private insurance companies (36.1%). Only small percentages assigned primary responsibility to the government (10.3%), the individual's family (7.4%), or charities (2.5%).

Respondents who assigned primary responsibility for payment to the affected individual were asked the follow-up question of who should be next most responsible. For the most part, responses to this follow-up item replicate those for primary responsibility with one notable difference. In those circumstances where the affected individual is unable to pay for the costs of mental health care, nearly half of the respondents believe that financial responsibility should fall on the families of the individual receiving the services.

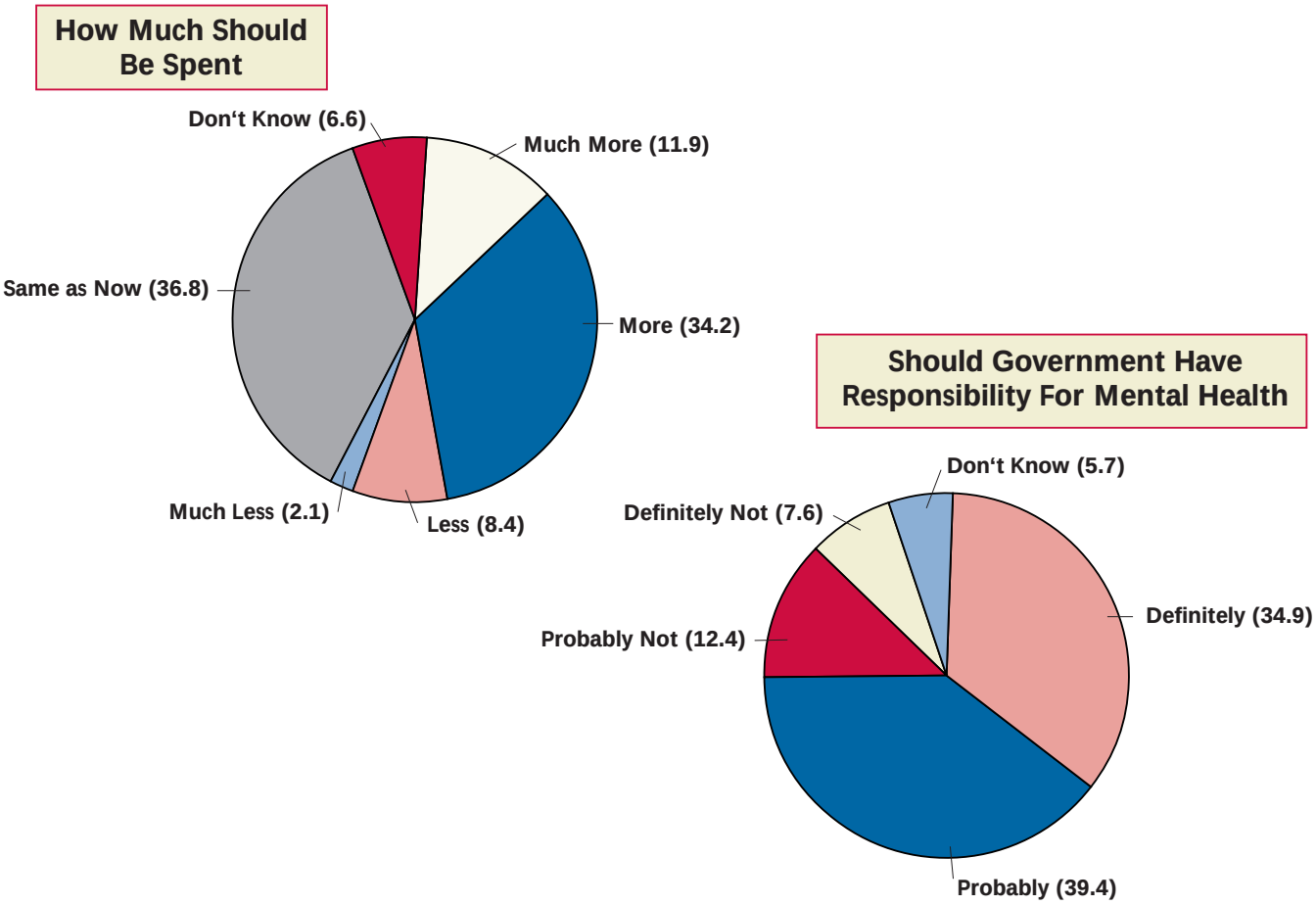
In addition to the responsibility for payment items, GSS respondents were asked to consider two mental health services policy items: 1) whether the government should be spending more on mental health care; and 2) whether it should be the government's responsibility to provide mental health care. Responses to these items are presented in Figure 12. Nearly half of the GSS respondents (46.1%) suggest that the government should be spending "much more" or "more" on mental health services, even if this extra spending might require a tax increase.

Figure 11. Percentage of Americans Indicating Sources of Responsibility to Pay for Mental Health Care



Moreover, only a small percentage (10.5%) would prefer the government to spend "less" or "much less" on these services. More surprising, however, are the responses to the question assessing government responsibility to provide mental health care. Recalling the pattern of responses outlined in Figure 11, where only a small proportion of respondents (10.3%) deemed the government to have primary responsibility for the payment of mental health treatment, it is noteworthy that over a third of those surveyed (34.9%) feel that the government "definitely" has the responsibility to provide mental heath care services. Further, an additional 39.4% indicate that the government "probably" should be responsible for these services.

Figure 12. Percentage of Americans Indicating Adequacy of Government Spending on Mental Health Care and Government Responsibility for Care



IX. Public Willingness to Interact Socially with Persons with Mental Health Problems.[3,7]

Throughout this report we have found evidence of a number of positive trends in how the American public views mental illness and those who suffer from mental health problems. For example, our analyses indicate: 1) that more now than in the past, Americans have adopted a broader, less stigmatizing definition of just what constitutes a mental health problem; 2) that relatively large numbers of Americans have at least some first-hand knowledge of persons suffering with mental health problems; and 3) perhaps as many as half of all Americans would like to see the government provide more in the way of mental health services. In light of these and other positive trends, an obvious question comes to mind. Are Americans at the turn of the century more willing than their earlier counterparts to interact on a routine basis with persons who have mental health problems?

In order to assess public attitudes toward interaction with the mentally ill, GSS respondents were asked a series of six "social distance" questions. Specifically, respondents were asked how willing they would be to: "move next door" to the person described in their vignette; whether they would "spend an evening socializing" with that person; whether they would "make friends" with that person; whether they were willing to "work closely on the job" with that person; whether they were willing to have the vignette person "marry into their family"; and whether they were willing to have a "group home for people like the vignette person in their neighborhood". The percentage of respondents who indicated that they were "definitely" or "probably unwilling" to interact with a person suffering from mental health problems in these six settings is reported in Table 11.

Examination of the data in Table 11 provides little evidence to suggest that the public is willing to interact socially or occupationally with persons suffering from mental health problems. Overall, the highest level of social distance is desired from persons with substance dependency problems. Indeed, when averaged across the six interactional categories, nearly three-fourths (71.8%) prefer to avoid contact with people who are drug dependent, and a majority (55.7%) also prefer to avoid persons who are alcohol dependent. While attitudes toward persons with problems other than substance abuse are somewhat more tolerant, it remains that a significant percentage of the public indicates a desire to remain socially distant from persons who have either schizophrenia or major depression. For example, on average, nearly half of all respondents (48.4%) report an unwillingness to interact with the person described in the schizophrenia vignette, and nearly 40 percent (37.4%) indicate a similar unwillingness to interact with persons suffering from major depression.

Without regard to type of mental health problem, the average percentages by type of interaction summarized in the bottom row of Table 11 are also instructive with regard to those social environments in which the public is most willing and least willing to have contact with persons with mental health problems. According to these data, respondents are most willing to be friends with persons suffering from these problems. For example, fewer than a quarter of respondents (23.1%) are unwilling to have a depressed person as a friend. Indeed, across the four mental health problems, only somewhat more than a third of respondents (38.2%) are unwilling to be friends with a person having mental health difficulties.

While it is clear that the vast majority or Americans are willing to make friends with persons with mental health problems, it is equally clear that this tolerance does not extend to a willingness to accept these persons as either family members or coworkers. Across the four mental health problem categories, on average, 75% of respondents are unwilling to have someone suffering from drug or alcohol dependency, schizophrenia, or depression marry a family member, and a similarly high 67.4% are unwilling to have persons suffering from these problems as coworkers.[3,7]

Looking within the body of Table 11, we see that Americans are most unwilling to have a person who is drug dependent marry into their family (89.0%). They are most willing to have the "troubled person" as their neighbor or friend. Only 9.5% and 10.0%, respectively, are unwilling to do so. Over a fifth of respondents reported an unwillingness to have the

troubled person as a co-worker (21.0%) or live in a nearby group home (27.7%), and nearly half do not want him/her to marry into their family (41.9%).[3,7]

With regard to the two traditional mental illness problems, depression and schizophrenia, the majority of respondents do not want to work alongside persons suffering from these problems, or have them marry into their family. Almost half are unwilling to have a person with depression as a close co-worker (48.6%), and almost two-thirds (64.1%) report a similar unwillingness to work with persons with schizophrenia. Moreover, a large majority of respondents are unwilling to have persons with mental illness marry into their family (68.6% for depression, 72.2% for schizophrenia).

The preferences for social distance reported in Table 11, then, provide little evidence to suggest that the stigma of mental illness has been reduced in contemporary American society. Levels of social rejection of those with mental health problems have remained distressingly high. There is, however, some reason to be guardedly optimistic about the prospects for the future. In a multivariate analysis of the correlates of social distance preferences (data not shown, ICMHSR Working Paper, No. 38), individuals who attributed the cause of mental illness to genetic or stress-related processes (i.e., processes outside the control of the individual) were significantly more accepting of persons with psychological problems across the six interactional settings.

Table 11. Percentage of Americans Reporting they are "Definitely" or "Probably Unwilling" to Interact with Vignette Person

	Social Interaction						
Vignette Story	Move Next Door %	Spend an Evening Socializing with %	Make Friend with %	Work Close with on the Job %	Have a Group Home in Neighborhood %	Marry into Your Family %	Average % by Vignette Type
Alcohol Dependence	45.6	55.8	36.7	74.7	43.4	78.2	55.7
Depression	22.9	37.8	23.1	48.6	31.2	60.6	37.4
Schizophrenia	37.0	49.0	34.0	64.1	33.2	72.2	48.4
Drug Dependence	75.0	72.7	59.1	82.0	52.7	89.0	71.8
Troubled Person	9.5	14.9	10.0	21.0	27.7	41.9	20.8
Average % by Type of Interaction	38.0	55.8	32.6	58.1	37.6	68.4	46.8

Adapted From: Martin, J.K., B.A. Pescosolido, and S.A. Tuch. 2000. "Of Fear and Loathing: The Role of 'Disturbing Behavior', Labels, and Causal Attributions in Shaping Public Attitudes Toward Persons With Mental Illness." *Journal of Health and Social Behavior,* 41(2): 208-233.

X. Summary

The complex picture of Americans' views of mental health and persons with mental health problems can be summarized along two dimensions: *differentiation* and *enduring stigmatization*. Encompassed within these themes are both positive patterns and causes for concern. In this section we comment on the overall sweep of the findings, and what they suggest for persons and families coping with mental health problems, treatment professionals, researchers, and policymakers.

Differentiation. In the 1950's, Shirley Star's research demonstrated that Americans' views of mental illness were negative, one-dimensional, and typified by the exemplar of the person with paranoid schizophrenia. Our findings indicate that the current understanding of mental health problems has become more differentiated, and in some cases, more positive. With remarkable consistency, Americans now recognize and correctly identify schizophrenia, major depression, alcohol disorder, and drug abuse as types of mental health problems. Moreover, they appear to be more willing to acknowledge that they personally have experienced "nervous breakdowns" or "mental health problems". Along these lines, Americans seem more able to make a distinction between mood and neurotic disorders, and psychotic and antisocial disorders. Also on the positive side, the causes of mental health problems are increasingly viewed as a result of the combined effects of life stressors, genetic, and chemical imbalances, rather than upbringing or bad character. These various mental health disorders are also seen as very amenable to treatment, including both medication and psychotherapies.

Enduring stigmatization. Unfortunately, accompanying this differentiation, mental health problems and mental illnesses appear to be viewed along a continuum of severity that continues to carry very strong, stigmatizing attitudes. Americans' contemporary attitudes toward mental illnesses have apparently become more infused with concerns about violence associated with these illnesses. Our data show that mental health problems can roughly be ordered from least to most stigmatized as follows: personal troubles, nervous breakdowns, major depression, schizophrenia, alcohol disorder, and drug disorder. Alcohol and drug problems are seen as having the highest potential for violence, followed by schizophrenia and depression. Closely linked to these fears of violence is a social distancing – not wanting to associate with individuals with these problems; believing they can not manage their own affairs; and believing that it is appropriate to coerce individuals into treatment. While there are more effective treatments for many of these conditions than ever before, the antipathy toward those with mental health problems remains distressing. These fears seem to fuel beliefs that it is appropriate to force individuals with substance abuse problems and schizophrenia into treatment, and to shun these individuals in work and in social life. Serious mental health problems continue to be stigmatizing and are coupled with fears of violence that appear to have increased significantly.

Implications for persons with mental health problems and family members. The most fundamental message to persons with mental health problems that can be gleaned from these data is that "you are not alone in your struggles with mental health problems." Indeed, one third of Americans admit to similar struggles, and half of all Americans know someone who is experiencing these problems. This is a time of tremendous advance in our ability to treat mental health problems both pharmacologically and with psychotherapy. Encouragingly, Americans recognize these advances. These data do send a clear message, however, that the fight against stigma is by no means finished. The coupling of violent stereotypes to images of mental illness suggests that stigma of severe mental illness and substance abuse may have become more negative over time.

Our findings do provide some evidence of a movement toward a general acceptance of less severe mental health problems as part and parcel of the normal problems of day-to-day life. The American public appears to have adopted the causal language of stressors, genetics, and chemical imbalance that make it easier to accept emergent mental health problems and pharmacologic and psychotherapeutic treatments. There is also an optimism about the efficacy of available treatments that parallels the actual demonstrated efficacy of new treatments. Increasingly, however, the first line of response for mental health problems are friends and family members. This realization

sets an agenda for mental health policies that targets social networks for accurate information about the recognition of mental health problems, inclusion of networks in treatment planning, and building social network strengths and competencies.

Implications for treatment providers and researchers. Our finding that the public has adopted psychotherapeutic models for mental health problems and supports the use of medication for the treatment of depression and schizophrenia is encouraging. There is also general sentiment that serious mental health problems aren't likely to get better on their own, and are responsive to modern treatment. A major goal of the Community Mental Health Movement has been to convince the American public to turn to therapists with their mental health problems, and this seems to have occurred. Unfortunately, however, repeated findings of community epidemiological studies demonstrates that most mental health problems continue to go untreated and unrecognized. It is likely that the stigma accompanying mental illness may continue to play a role in discouraging help-seeking.

Hopefully these findings will reinforce for mental health professionals the realization that mental health stigma is still alive and well in modern society. Thus, patients accepting the diagnosis of, and receiving treatment for, psychiatric disorders will continue to struggle, both personally and within social circles. To begin, there is pressure and reinforcement to deny one's problems. Second, there are potential social costs associated with acknowledging a serious mental illness, such as the temptation to "feel" well too quickly, and to go off the medications or stop therapy visits that are the "badge" of mental health patient status. For these and other reasons, it will be difficult for professionals to inform mental health patients of the many months or years they may have to take medications or continue therapy in order to prevent relapse.

These themes raise a number of important mental health services research questions. Obviously, given the findings of this study, the increased public linkage of violence and mental illness warrants continued research. Is this pattern part of a general tendency of the public to view violence as on the rise, even when violent crimes are on the decline overall, or is this perception driven by media portrayals of the crack cocaine epidemic, or by mentally ill loners on senseless rampages? These are important research issues that bear continued scrutiny.

The questions of coerced treatment also raise important issues, especially for substance abuse services. Public policy in the 1980's and 1990's was increasingly turned toward criminalizing substance abusers and persons with mental illness. Despite the fact that diversion treatment programs have been widespread, however, there has been little research on the effectiveness of treatment programs as alternatives to incarceration. The issue of coerced treatment needs to be studied more systematically given the overwhelming public sentiment to require such treatment for more serious mental illnesses.

Policy Implications. Since the Reagan administration decentralized federal health care in the mid-1980's, there has not been a well-articulated national mental health policy. Indeed, over the last decade, the United States has become a nation of 50 state-wide experiments with a strong private sector overlay of managed behavioral care. Our study indicates that, despite progress on some fronts, there is still strong public antipathy toward persons with severe mental illness. Unfortunately, advocates for persons with mental illness are forced to fight a fifty-front war and still have little influence over nationally-protected health maintenance organizations. Perhaps these findings will prove to be of some help in articulating mental health needs in this fractured policy climate.

The message to both citizens and policy makers is clear: the public believes treatment for serious mental illness is effective and believes that the government should be responsible for assuring the availability of mental health care. A near majority call for increased government funding for treatment. Left untreated, the public believes serious mental illness will not improve. At a time when the mental health care system is undergoing tremendous strain and transformation, these findings send a clear message that the public values access to both medical and non-medical mental health professionals' care. While there is confidence that treatment works, the public is still somewhat reluctant to use services for their own problems. Our data indicate that government-mandated mental health services and health insurance plans that include parity for mental health care are valued by the public. Americans believe they should pay their share of the cost for services, but it would appear that most Americans believe that the government has a mandate to insure access and availability of mental health care services.

XI. List of Scientific Publications, Papers, and Presentations

1. Phelan, J.C., B.G. Link, A. Stueve, and B.A. Pescosolido. 2000. "Public Conceptions of Mental Illness in 1950 and 1996: What is Mental Illness and Is It to be Feared?" *Journal of Health and Social Behavior,* 41(2): 188-207.

2. Swindle, R., K. Heller, B.A. Pescosolido, and S. Kikuzawa. 2000. "Responses to 'Nervous Breakdowns' in America Over a 40-year Period: Mental Health Policy Implications." *American Psychologist*, 55(7).

3. Link, B.G., J.C. Phelan, M. Bresnahan, A. Stueve, and B.A. Pescosolido. 1999. "Public Conceptions of Mental Illness: Labels, Causes, Dangerousness, and Social Distance." *American Journal of Public Health* 89(9): 1328-1333.

4. Pescosolido, B.A., J. Monahan, B.G. Link, A. Stueve, and S. Kikuzawa. 1999. "The Public's View of the Competence, Dangerousness, and Need for Legal Coercion of Persons With Mental Health Problems. *American Journal of Public Health* 89(9): 1339-1345.

5. Schnittker, J. 2000. "Gender and Reactions to the Mentally Ill: An Examination of Social Tolerance and Perceived Dangerousness." *Journal of Health and Social Behavior*, 41(2): 234-240.

6. Steuve, A. and C.A. Boyer. "Public Perceptions of Government Responsibility for Mental Health Care." Presented at the Health Services Research Group Combined Conference, Indiana University and Eli Lilly & Company, Indianapolis, IN. 1997.

7. Martin, J.K., B.A. Pescosolido, and S.A. Tuch. 2000. "Of Fear and Loathing: The Role of 'Disturbing Behavior', Labels, and Causal Attributions in Shaping Public Attitudes Toward Persons With Mental Illness". *Journal of Health and Social Behavior,* 41(2): 208-233.

TECHNICAL APPENDIX

A. The Vignettes

Vignette A: Alcohol Dependence
NAME is a RACE/ETHNICITY, MAN/WOMAN, who has completed EDUCATION. During the last month NAME has started to drink more than his/her usual amount of alcohol. In fact, s/he has noticed that s/he needs to drink twice as much as s/he used to to get the same effect. Several times, s/he has tried to cut down, or stop drinking, but s/he can't. Each time s/he has tried to cut down, s/he became very agitated, sweaty, and s/he couldn't sleep, so s/he took another drink. His/her family has complained that s/he is often hungover, and has become unreliable, making plans one day, and canceling them the next.

Vignette B: Major Depressive Disorder
NAME is a RACE/ETHNICITY, MAN/WOMAN, who has completed EDUCATION. For the last two weeks NAME has been feeling really down. S/he wakes up in the morning with a flat, heavy feeling that sticks with her/him all day long. S/he isn't enjoying things the way s/he normally would. In fact, nothing seems to give him/her pleasure. Even when good things happen, they don't seem to make NAME happy. S/he pushes on through her/his days, but it is really hard. The smallest tasks are difficult to accomplish. S/he finds it hard to concentrate on anything. S/he feels out of energy and out of steam. And even though NAME feels tired, when night comes s/he can't get to sleep. NAME feels pretty worthless, and very discouraged. NAME'S family has noticed that s/he hasn't been him/herself for about the last month, and that s/he has pulled away from them. NAME just doesn't feel like talking.

Vignette C: Schizophrenia
NAME is a RACE/ETHNICITY, MAN/WOMAN, who has completed EDUCATION. Up until a year ago, life was pretty okay for NAME. But then, things started to change. S/he thought that people around him/her were making disapproving comments, and talking behind his/her back. NAME was convinced that people were spying on him/her and that they could hear what s/he was thinking. NAME lost his/her drive to participate in his/her usual work and family activities and retreated to his/her home, eventually spending most of his/her day in his/her room. NAME became so preoccupied with what s/he was thinking that s/he skipped meals and stopped bathing regularly. At night, when everyone else was sleeping, s/he was walking back and forth in his/her room. NAME was hearing voices even though no one else was around. These voices told him/her what to do and what to think. S/he has been living this way for six months.

Vignette D: Drug Dependence
NAME is a RACE/ETHNICITY, MAN/WOMAN, who has completed EDUCATION. A year ago, NAME sniffed cocaine for the first time with friends at a party. During the last few months, s/he has been snorting it in binges that last several days at a time. S/he has lost weight and often experiences chills when binging. NAME has spent his/her savings to buy cocaine. When NAME'S friends try to talk about the changes they see, s/he becomes angry and storms out. Friends and family have also noticed missing possessions and suspect NAME has stolen them. S/he has tried to stop snorting cocaine, but can't. Each time s/he tries to stop, s/he feels tired, depressed, and is unable to sleep. S/he lost his/her job a month ago, after not showing up for work.

Vignette E: Troubled Person
NAME is a RACE/ETHNICITY, MAN/WOMAN, who has completed EDUCATION. Up until a year ago, life was pretty okay for NAME. While nothing much is going wrong in NAME'S life, s/he sometimes feels worried, a little sad, or has trouble sleeping at night. NAME feels that at times things bother him/her more than they bother other people and that when things go wrong, s/he sometimes gets nervous or annoyed. Otherwise, NAME is getting along pretty well. S/he enjoys being with other people and although NAME sometimes argues with his/her family, NAME has been getting along pretty well with his/her family.

B. General Introduction to the MacArthur Mental Health Module

Vignette Strategy. Although it is possible to address Americans' knowledge, attitudes and beliefs about mental illness through standard survey questions, we decided instead on a vignette experiment designed to address these components. One advantage of vignettes is that they allow tests to be more disguised, and thus less biased by inclinations toward social desirability (see Link et al. 1987; Link and Cullen 1983). The American public's sophistication regarding "proper" expressions of opinion concerning individuals with mental illness or other disabilities make the use of the standard approach questionable. Another advantage of using vignettes is that, by using what we call a Rossi Vignette (Rossi and Nock 1982), it iss possible to vary many aspects in the vignette and thus to test more theoretical issues. Link's pre-test work suggests that the vignette strategy worked very well (1994, 100 cases). In sum, the "science" in the area of mental health, the experience of the research team in using and successfully publishing vignette data, and the nature of the topic make the use of vignettes both necessary and plausible. Respondents answered the questions relevant to *one* vignette only.

We chose to construct a series of new vignettes based on *DSM-IV* criteria, using a technique developed by Rossi and Nock (1982). In the Rossi technique one creates a profile of characteristics or situations that are varied at random in the vignettes. Thus instead of varying only a few characteristics, as in a factorial experiment, one varies many characteristics.

Three characteristics were varied—sex (male/female), race-ethnicity (white, black, Hispanic), and education.

We wrote 5 vignettes—four depicting DSM-IV disorders and one depicting a person with minor, subthreshold problems. The disorders we have included are schizophrenia, major depression, alcohol dependence, and drug dependence (using cocaine as the specific drug). These disorders were chosen on the basis of severity, prevalence, and the potential consequences of misidentification (e.g., failure to receive a readily available and effective treatment).

Having framed the vignette in this way, we asked respondents their opinion about (1) how serious the situation is; (2) what kind of problem, if any, is presented; (3) what the person in the vignette should do about it; and (4) what might cause such a problem. In addition, we included items that allow us to create multiple-item scales assessing social distance and perceived dangerousness. The social distance scale includes five items asking how willing the respondent would be to live next door to, have work in the local school, have as a close friend, work on the same job with, or spend an evening socializing with the person described in the vignette. We examined danger and control by asking how dangerous the person might be and whether the respondent thought the person might unexpectedly do something violent.

The Actual Problem. Here we focused on documenting and explaining change in the use of informal and formal treatment for individuals experiencing mental health problems. In *AVMH*, the stem question involved "nervous breakdown". The Star study refers often to this condition as well. The team spent a good deal of time discussing the potential for comparability using this stem. Gove (1989), for example, argues that using the term "nervous breakdown" avoids the stereotype of "mental illness" and engenders few, if any, labeling effects. Some members of the research team felt that this would produce an age-related bias in results, with older respondents providing comparable information to the 1950's studies but younger respondents answering no (even if they had experienced problems) because of the lack of contemporary meaning. Our solution involved the development of a two stage introduction – the first, which replicates *AVMH* exactly, asks whether individuals ever thought they were having a "nervous breakdown". We followed that with a second question which asks

whether the respondent has ever experienced "mental health problems". This allowed us to replicate analyses directly. However, through a comparison of the responses to the two stem questions, we can assess the bias in using the "older" language and analyze the entire subsample acknowledging problems. In addition, the qualitative data available from the question in the Star study, "As far as you know, what is a nervous breakdown?", allowed us to directly examine meaning across time.

Both the family and consumer movements in mental health have emphasized the stigma of mental illness as a major concern. Their stance on how familiarity with and understanding of mental illness impacts stigma makes our information on how many people in the U.S. know and are related to persons with mental health problems very useful. In addition, under current policy initiatives, they have become increasingly concerned with issues of coercion and who is responsible for the care and funding of mental health care.

C. The General Social Survey

The General Social Survey is a nation-wide survey of opinion, attitudes and behaviors of the American Population. Considered the premier thermometer of the climate of American opinion, the GSS data are routinely used and GSS staff are regularly consulted by scholars, policy makers and Congressional staff. Over 1,000 articles and reports have been published based on GSS data (see Annotated Bibliography, Smith 1995). The GSS has existed since 1972, primarily under the sponsorship of the National Science Foundation, and represents the longest running longitudinal survey of the American population (it is NOT a panel design; the samples are probability samples of the US population). The profile of American opinion is representative with response rates ranging from the 72% (in 1982) to 82% (in 1993; these mirror trends in national response rates, generally).

The Survey is fielded by NORC (University of Chicago), one of the best polling operations in the US. Under the current grant cycle, the survey operates under an every-other-year design although the number of cases remain the same over the two years (in essence, they are doing a "double" survey in each two-year period – approximately 3,000 cases total). Since 1977, GSS has included "Topical Modules" on race, religion, the military and abortion in addition to a set of core questions. Each module is attached to only one of the samples (A or B) but previous methodological research indicates that the N = 1,500 to 1,800 is sufficient to provide a representative view of American opinion.

D. The Survey Instrument

X FORM: ASK QS1. **Y FORM: SKIP TO VIGNETTES, QS2.**

1. Problems often come up in life. Sometimes they're personal problems – people are very unhappy, or nervous and irritable all the time. Sometimes there are problems in a marriage – a husband and wife just can't get along with each other. Or, sometimes it's a personal problem with a child or a job. I'd like to ask you a few questions now about what you think a person might do to handle problems like this.

   For instance, let's suppose you had a lot of personal problems and you're very unhappy all the time. Let's suppose you've been that way for a long time, and it isn't getting any better. What do you think you'd do about it?

   _____

   _____

   _____

   _____

ASK q2-q15 of EVERYONE
VIGNETTES (See Appendix A for text of vignettes.)

Next I'm going to describe a person – lets call him/her NAME. After I read a description of him/her I'll ask you some questions about how you think and feel about him/her. There are no right or wrong answers. I'm only interested in what you think of NAME.

INTERVIEWER: READ SELECTED VIGNETTE, THEN GIVE CARD TO R FOR REFERENCE.

2. Please remember, there are no right or wrong answers to these questions. Please think about the person I just described when answering this group of questions. First, how serious would you consider (NAME'S) problem to be – very serious, somewhat serious, not very serious, or not at all serious?

   1 Very able
   2 Somewhat able
   3 Not very able
   4 Not able at all
   8 Don't Know

---

3. In your opinion, how likely is it that NAME's situation might be caused by **(READ a-f)** – very likely, somewhat likely, not very likely, or not at all likely?

	Very Likely	Somewhat Likely	Not Very Likely	Not at all Likely
a. His/her own bad character				
b. A chemical imbalance in the brain				
c. The way (s/he) was raised				
d. Stressful circumstances in his/her life				
e. A genetic or inherited problem				
f. God's Will				

4. In your opinion, how likely is it that NAME is experiencing **(READ a-e)** – very likely, somewhat likely, not very likely, or not at all likely?
(In Part e, read only the phrase following the letter of the Vignette.)

	Very Likely	Somewhat Likely	Not Very Likely	Not at all Likely
II Part of the normal ups and downs of life.				
b. A nervous breakdown				
c. A mental illness				
d. A physical illness				
e. MARK VIGNETTE & READ **only 1** PHRASE OF FOLLOWING: __ Vignette A: alcohol dependence __ Vignette B: a major depression __ Vignette C: schizophrenia __ Vignette D: a drug problem __ Vignette E: (SKIP to 5)				

5. In your opinion, how able is NAME to make his/her own decisions about the treatment s/he should receive – very able, somewhat able, not very able or not able at all?

1 Very able
2 Somewhat able
3 Not very able
4 Not able at all
8 Don't Know

6. In your opinion, how able is NAME to make his/her own decisions about managing his/her own money – very able, somewhat able, not very able or not able at all?

1 Very able
2 Somewhat able
3 Not very able
4 Not able at all
8 Don't Know

7. In your opinion, how likely is it that NAME'S situation will improve on its own – very likely, somewhat likely, somewhat unlikely, or not likely at all?

   1 Very likely
   2 Somewhat likely
   3 Somewhat unlikely
   4 Not likely at all
   8 Don't Know

---

8. In your opinion, how likely is it that NAME'S situation will improve with treatment – very likely, somewhat likely, somewhat unlikely, or not likely at all?

   1 Very likely
   2 Somewhat likely
   3 Somewhat unlikely
   4 Not likely at all
   8 Don't Know

9. How willing would you be **(READ a-f)** – definitely willing, probably willing, probably unwilling, or definitely unwilling?

	Definitely Willing	Probably Willing	Probably Unwilling	Definitely Unwilling
a. To move next door to NAME?				
b. To spend an evening socializing with NAME?				
c. To make friends with NAME?				
d. To have NAME start working closely with you on a job?				
e. To have a group home for people like NAME opened in your neighborhood?				
f. To have NAME marry into your family?				

10. In your opinion, how likely is it NAME would do something violent toward other people. Is it:

1 Very likely
2 Somewhat likely
3 Not very likely
4 Not likely at all
8 Don't Know

11. In your opinion, how likely is it NAME would do something violent toward him/herself. Is it:

1 Very likely
2 Somewhat likely
3 Not very likely
4 Not likely at all
8 Don't Know

ALLOWED DEFINITION: violent toward self: suicide, not eating, wandering in traffic, self-mutilation

---

12. Should NAME do any of the following:

	Should Do: (YES=1 NO=5 DK=8)	**Order**
Talk to family and friends about it		
Talk to a minister, priest, rabbi or other religious leader		
Go to a general medical doctor for help		
Go to a psychiatrist for help		
Go to a therapist, or counselor, like a psychologist, social worker, or other mental health professional for help		
Go to a spiritual or a natural healer for help		
Join a self-help group where people with similar problems help each others		
Take non-prescription medication, like over the counter sleeping pills		
Take prescription medication		
Check into a mental hospital		

---

13. Here are the things you said NAME should do. In what order should s/he do them? (INTERVIEWER; Sequence list after respondent reads.)

14. Some cities and states have laws that force people with problems like NAME into treatment. Do you think that people like NAME should be forced by law to?

	Yes	No	DK
a. Get treatment at a clinic or from a doctor	1	5	8
b. Take a prescription medication to control his/her behavior	1	5	8
c. Be admitted to a hospital for treatment	1	5	8
d. Be admitted to a hospital for treatment if s/he is dangerous to him/herself	1	5	8
e. Be admitted to a hospital for treatment if s/he is dangerous to others	1	5	8

15. In your opinion, who should be most responsible for paying the cost of NAME's medical care, including mental health care and and treatment:

1 NAME, him/herself ⟶	Who should be next most responsible?
2 his/her family	1 his/her family
3 government	2 government
4 insurance	3 insurance
5 private charity	4 private charity
8 DK	8 DK

Let's turn away from NAME, now. Retrieve vignette. **Form x, ask q16. Form y, go to q 17.**

16. Earlier, we talked about various areas of government spending. Since we've been talking about the mental health area, please indicate whether you would like to see more or less government spending in the area of mental health care. Remember that if you say "much more," it might require a tax increase to pay for it.
IF R ANSWERS BY SAYING NAME DOES NOT REQUIRE CARE, REMIND HIM/HER WE'RE NOT TALKING ABOUT NAME ANYMORE

1 Spend much more
2 Spend more
3 Spend the same as now
4 Spend less
5 Spend much less
8 Can't choose
9 No answer

Form x, go to q19, Form y ask 17 & 18.

---

17. On the whole, do you think it should or should not be the government's responsibility to provide health care for persons with mental illnesses?
IF R ANSWERS BY SAYING NAME DOES NOT REQUIRE CARE, REMIND HIM/HER WE'RE NOT TALKING ABOUT NAME ANYMORE

1 Definitely should be
2 Probably should be
3 Probably should not be
4 Definitely should not be
8 Can't choose
9 No answer

18. Of course, everybody hears a good deal about physical illness and disease, but now, what about the ones we call mental or nervous illness?...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?)**

_____

_____

_____

_____

Form Y, skip q 19-22
Form X, ask q 19-22

19. 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?)**

_____

_____

_____

_____

20. Did you ever know anyone who was in a hospital because of a mental illness?

1 Yes
5 No **GO TO 22**
8 Not Sure **GO TO 22**

21. **(IF YES)** Was this a relative, a close friend, or just someone you didn't know very well? **(CIRCLE ALL THAT APPLY)**

1 Respondent
2 Immediate family
3 Other relatives
4 Close friends
5 Acquaintances
6 Other (specify) _____
7 Won't say
8 Don't Know

22. Have you ever known anyone (other than persons mentioned above) who was seeing a psychologist, mental health professional, social worker or other counselor?

1 Yes
5 No
8 Don't know

Ask of Everyone

23. Have you ever felt that you were going to have a nervous breakdown?

1 Yes **(GO TO 23a)**
5 No **(GO TO 23c)**
8 Don't Know **(GO TO 23c)**

23a. **(IF EVER ANTICIPATED A NERVOUS BREAKDOWN)** Could you tell me about when you felt that way? What was it about? **(PROBE: GET EXACT DATE and complete details.)**

_____

_____

_____

23b. **(IF EVER ANTICIPATED A NERVOUS BREAKDOWN)** What did you do about it? (PROBE: Anything else? until R says no.) Which of these things would you do first; second; third? **(INTERVIEWER: Sequence list; read back if needed.)**

_____

_____

_____

_____

IF ANSWERED 23a & 23b, GO TO end/next section.

23c. **(IF NO TO 23,)** Did you ever feel you had a mental health problem?

1	Yes	**(GO TO 23d &e)**
5	No	**(GO TO next section/end)**
8	Don't Know	**(GO TO next section/end)**

23d. **(IF EVER FELT HAD MENTAL HEALTH PROBLEM)** Could you tell me about when you felt that way? What was it about? **(PROBE: GET EXACT DATE and complete details.)**

_____

_____

_____

23e. **(IF EVER FELT HAD MENTAL HEALTH PROBLEM)** What did you do about it? **(PROBE: Anything else? until R says no.)** Which of these things would you do first; second; third? **(INTERVIEWER: Sequence list; read back if needed.)**

_____

_____

_____

_____

GO TO NEXT SECTION/END

E. Data Sets Referenced and Bibliography

A. Data Sets Referenced

Star, Shirley. 1950. "Survey 272", National Opinion Research Center, University of Chicago, May.

Gurin, Gerald, Joseph Veroff, and Sheila Feld. 1957. *Americans View Their Mental Health*. (SSA #3503; SRC #42,434) 1975 Codebook. (Survey entitled "Study of Modern Living").

Veroff, Joseph, Elizabeth Douvan, and Richard A. Kulka. 1976. *Americans View Their Mental Health*. (ICPSR 7948). 1982 Codebook. Ann Arbor, MI: Inter-University Consortium for Political and Social Research. (Survey entitled "Study of Modern Living").

B. References

Clausen, John. 1989. "Labeling Mental Illness." Paper presented at the *Society for Social Problems* Meetings, Berkeley, California.

Gove, Walter. 1989. "On Understanding Mental Illness and Some Insights to be Gained from the Labeling Theory of Mental Illness." Paper presented at the *Society for the Study of Social Problems* meetings, Berkeley, California.

Kadushin, Charles. 1969. *Why People Go to Psychiatrists*. New York: Atherton.

Link, Bruce. 1987. "Understanding Labeling Effects in the Area of Mental Disorders: An Assessment of the Effects of Expectations of Rejection." *American Sociological Review* 52: 96-112.

Link, Bruce G. and Francis T. Cullen. 1983. "Reconsidering the Social Rejection of Ex- Mental Patients: Levels of Attitudinal Response." *American Journal of Community Psychology* 11: 261-73.

_____. 1990. "The Labeling Theory of Mental Disorder: A Review of the Evidence." in *Mental Illness in the United States*. Edited by James Greenley. Greenwich CT: JAI Press.

Link, Bruce G., Francis T. Cullen, James Frank, John F. Wozniak. 1987. "The Social Rejection of Former Mental Patients: Understanding Why Labels Matter." *American Journal of Sociology* 92: 1461-1500.

Link, Bruce G., Francis T. Cullen, Elmer Struening, Patrick Shrout and Bruce P. Dohrenwend. 1989. "A Modified Labeling Theory Approach in the Area of the Mental Disorders: An Empirical Assessment." *American Sociological Review* 54: 400-423.

Rossi, Peter and Steven Nock. 1982. *Measuring Social Judgments*. Beverly Hills: Sage.

Shapiro, Sam, Elizabeth Skinner, Larry Kessler et. al. 1984. "Utilization of Health and Mental Health Services: Three Epidemiologic Catchment Area Sites." *Archives of General Psychiatry* 41: 971-978.

Spiro, Herzl, Iradj Siassi and Guido Crocetti. 1973. "Ability of the Public to Recognize Mental Illness: An Issue of Substance and an Issue of Meaning." *Social Psychiatry* 8: 32-36.

Star, Shirley. 1955. *The Public's Ideas About Mental Illness*. Chicago: National Opinion Research Center (Mimeographed).

Thoits, Peggy. 1995. "Stress, Coping and Social Support Processes: Where Are We? What Next?" *Journal of Health and Social Behavior*. (Extra Issue).