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# **SOCIAL PSYCHIATRY AND COMMUNITY ATTITUDES**

## **Seventh Report of the Expert Committee on Mental Health**

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WORLD HEALTH ORGANIZATION

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## EXPERT COMMITTEE ON MENTAL HEALTH

Geneva, 20-25 October 1958

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# **SOCIAL PSYCHIATRY AND COMMUNITY ATTITUDES**

## **Seventh Report \* of the Expert Committee on Mental Health**

The WHO Expert Committee on Mental Health met in Geneva from 20 to 25 October 1958 to consider the role of social psychiatry in combating mental illness and the way in which its application is affected by community attitudes. Dr R. H. Felix was elected Chairman and Dr Phon Sangsinkeo, Vice-Chairman ; Dr Maxwell S. Jones and Dr T. A. Lambo were elected Rapporteurs.

### **1. NATURE AND GOALS OF SOCIAL PSYCHIATRY**

#### **1.1 Working definition of social psychiatry**

The term "social psychiatry" has come into use relatively recently and has acquired different shades of meaning according to author and environment. As employed here, social psychiatry refers to the preventive and curative measures which are directed towards the fitting of the individual for a satisfactory and useful life in terms of his own social environment. In order to achieve this goal, the social psychiatrist attempts to provide for the mentally ill, and for those in danger of becoming so, opportunities for making contacts with society which are favourable to the maintenance or re-establishment of social adequacy.

In this definition two fundamental premises are implied. The first is that mentally ill individuals can be fitted into a more complex social environment, and the second that the provision of adequate opportunities for favourable social contacts is useful for the prevention and cure of mental

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\* The Executive Board, at its twenty-fourth session, adopted the following resolution :  
The Executive Board

1. NOTES the seventh report of the Expert Committee on Mental Health (Social Psychiatry and Community Attitudes) ;
  2. THANKS the members of the Committee for their work ; and
  3. AUTHORIZES publication of the report.
- (Resolution EB24.R11, *Off. Rec. Wld Hlth Org.*, 1959, 96)

disorder. These premises are by no means new ; they belong to the basic principles which have at all times influenced the practices and aspirations of psychiatrists. However, their value has not always been appreciated with sufficient clarity and their systematic formulation and application is a relatively recent development of psychiatric science.

Without going extensively into historical details, it may be recalled that "moral treatment", as conceived by Pinel and his contemporaries, was to a great extent based on these premises, and the same applies to approaches of later generations in England (Connolly), the United States (Dorothea Dix), Switzerland (Eugen Bleuler) and Germany (Simon), to mention a few outstanding names in historical order. In this context, reference should also be made to occupational therapy or, rather, therapeutic occupation, long recommended by distinguished psychiatric therapists of all nations. The most advanced protagonists of occupational therapy have always insisted that its chief goal is neither to reach a high output of products nor to hold the patient out of harm's way by keeping him busy, but rather to offer him opportunities for social contact which will be beneficial to the adequate development of his personality. Occupational therapy has also often been used as a means of getting hospitalized patients outside the walls of a mental hospital and leading them back into a more normal type of social existence. A further step in the same direction has been the organization of foster family care, that is the placement of patients in suitable families outside a psychiatric establishment.

This trend has developed considerably in recent times, partly owing to advances in physical treatment in psychiatric practice. The fact that malaria treatment, insulin coma, electro-convulsive therapy, and the introduction of new drugs have made it possible to improve the functioning of the mentally sick individual has created many new needs and opportunities for social reintegration. Social treatment and social psychiatry as a whole are indeed by no means incompatible with individual treatment on strictly medical lines. They are, in fact, complementary.

A deeper psychological penetration into the dynamics of mental disorder and the acquisition of better techniques of psychological treatment have also enlarged the field of psychiatric practice, both in depth and in scope. Psychopathological research and psychotherapeutic experience have made it possible for psychiatrists not only better to understand the role of patients in their environment, but also to extend psychiatric treatment to many behaviour disorders which before had hardly ever received the benefit of rational and systematic therapy. These advances were important for the development of social psychiatry, since the significance of social conditions in the causation, as well as in the prevention and care of mental illness, is most evident in patients whose disorders are psychotherapeutically accessible. Indeed, the goals of psychotherapy and social psychiatry can be said to overlap.

## 1.2 Other conceptions of social psychiatry

As mentioned above, the term social psychiatry has also other connotations. Thus one author has recently said that the significant phenomenon of social psychiatry is "the mentally ill person in the social context". In this very ample sense, social psychiatry comprises all areas where mental illness and the functioning of society come into contact, including the details of administrative and forensic practice and the techniques of community development.

There are other definitions which apply the adjective "social" only to activities concerning the welfare of persons usually protected by such institutions as social security systems, etc. Some recent research has indeed shown that the underprivileged strata of society may also be underprivileged in respect of the psychiatric care they receive. Thus, arrangements which put complete psychiatric care within the reach of all have been termed social psychiatry, although they belong perhaps more to the field of social policy than that of social medicine.

Another concept of social psychiatry defended by some authors is that, on the strength of a better understanding of the consequences of social patterns for individual psychological dynamics, the knowledge acquired in psychiatric practice might be applied on a large scale to the understanding of social dynamics, and that social psychiatry might eventually provide the means of creating a saner or perhaps a completely sane world. According to some, the techniques used by psychiatrists in the maintenance and re-establishment of social adequacy in persons under stress could be developed into a body of information upon which a new discipline, "sociatry", could be based, the functions of which would be the diagnosis, treatment and prevention of "unhealthy" social structures.

Where this notion is entertained without the necessary reservations it may lead into very doubtful territory. It has been pointed out that mental health and mental ill-health can be considered as pertaining only to a living organism with mental faculties and not to any other entity. Calling societies healthy or sick introduces in any case value judgements which might be better avoided.

It may be said, however, that there are societies which are more or less *conducive* to healthy or unhealthy behaviour and it is to be expected that adequate consideration of this notion will become increasingly important for our thinking in the areas of social psychiatry and social medicine generally. A full picture of the culture and of the social structure in which the individual develops towards mental health and mental illness is undoubtedly a prerequisite of any sound analysis and effective action. Knowledge of the concepts of normality and abnormality in different cultures and of the degrees of tolerance shown towards various kinds of behaviour is of fundamental importance in social psychiatry. The whole

range of normal as well as abnormal personality development is relevant in this context. Moreover, it is essential to be aware of the influence and importance of community institutions such as organized religion, the law, schools, and the family.

### 1.3 Role of social psychiatry in different types of community

It is of course realized that considerations of this nature are to some extent abstract. Much more investigation is required before their importance can be properly assessed. One important field of inquiry is the specific role played by culture and social structure in the life of persons whose mental health is in danger or who are actually suffering from mental disorder. In this connexion, it should be remembered that at different stages of his development every individual belongs simultaneously to a number of social structures. When investigating the impact of society on the individual it will therefore be necessary to define the "effective" community or social structure to which he is considered to belong.

In whatever way a society may be organized, it is not so much the type of mental disorder that varies as the community's reaction to abnormal behaviour.

In relatively unchanged agrarian societies, there is generally little provision in hospitals and communities for the mentally sick, and the few cases that are found in such places are usually very serious. At the same time, there are large numbers of other psychiatric casualties living harmlessly and unnoticed within an extended kinship group. Since the mentally sick person cared for by members of the family or tribe as a normally accepted duty is generally less likely to exhibit grossly disturbed behaviour, the results of this practice are often very good. However, the prognosis for the individual sick person may be worse, because the need for medical treatment may not be recognized and, from the very nature of the social organization, it may be impossible to bring such treatment to the patient. It is important to emphasize that when social psychiatry is introduced into a society of this type it must be fitted into the social pattern of the community which it serves. It is unrealistic, for example, in a slowly changing society to demand the hospitalization of all patients with serious mental illness, for then they would have to be reintegrated in the joint family system at a later stage. Instead, in these circumstances, the aim should be to bring such skilled help as is available to the patient within the family setting.

Within more rapidly changing societies, there are likely to be other problems. First, psychiatric illness is often intimately bound up with the patient's failure to adapt to environmental conditions—a failure that may be more complete when the whole pattern of society is also undergoing change. Secondly, reintegration into society, which is an essential part

of recovery from psychiatric illness, may be more difficult when the society is in a process of change.

In the societies that have been more profoundly affected by the industrialization and concomitant social changes of the last 150 years, there is one common feature which is of fundamental importance in considering the goals of social psychiatry: in nearly all these countries the mentally ill patient has been increasingly excluded from society during the period of his illness. Thus, in the countries that first experienced the massive social changes of the industrial revolution, the population movements and social upheavals of the mid-nineteenth century led to the creation of enormous mental hospitals, situated remote from big cities, in which the patients and staff lived a life of their own, cut off from the community. It required a legal certificate either to get a patient into or out of these institutions; and, significantly, the doctor empowered to sign such certificates was termed an "alienist". This social rejection of the mentally sick has created an extraordinary set of artificial conditions. The mentally sick individual, having been excluded from the community for the duration of his illness, then had to be reintegrated into the social community. This, broadly speaking, has been the goal of social psychiatry in these countries. Advances have been made in introducing easier certification proceedings; voluntary admission to hospital without certificate; the open-door principle; day hospitals; night hospitals; and therapeutic social clubs. But this is still insufficient. Psychiatrists now see that their therapeutic aims can be achieved only by getting right away from the practice of excluding the psychiatric patient from society. However, they also realize that this exclusion is not just a matter of certificates and locked hospital doors, but depends to a very large extent on the attitude of the ordinary man and woman to psychiatric illness and psychiatric practice.

The psychiatrist is nowadays often able to place a person at the door through which he can step out into normal life, but this action will not have the desired effect if outside that door there is only empty space. If society is to reap the full benefit of the advance of modern psychiatry, it must learn to collaborate in the prevention of mental disorder and in the therapy and rehabilitation of the mentally ill. In other words, further progress now largely depends on the attitudes of the community towards mental patients and towards social psychiatry itself.

## 2. THE COMMUNITY AND ITS MENTALLY ILL

### 2.1 Sources of information

If community co-operation in the preventive and therapeutic endeavours of social psychiatry is to be achieved, it will obviously be necessary first to obtain a clear picture of the existing position of the mentally ill within

the community. Research on this question has started in various parts of the world, but for many areas the only information available comes from the impressions of scattered observers or has to be inferred from indirect sources.

Attitude research, such as is developed in a number of countries by sociologists and social psychologists, will be of great assistance to social psychiatrists in providing the basic data required before further action is planned. An outstanding example of such research examined by the Committee is that started in May 1950 by the National Opinion Research Center of the University of Chicago (the NORC study). More than 3500 adults, representing a national cross-section of the American community, were subjected to intensive interviews. The major goals of the project were stated to be "first, to describe in some detail the characteristic ideas about mental illness current in our society, and, second, to explain—so far as we can—the reasons why popular conceptions of mental illness assume the form they do".

More recently, studies have been started at the University of Illinois and reported in a preliminary form under the title "The development and change of popular conceptions of mental health and mental illness."

Another piece of attitude research is the current study by the Social Psychiatry Research Unit at the Institute of Psychiatry in London. This is a comparative study between a mining community and a rural community which is being carried out in three fields: (a) the social structure of the two communities; (b) the attitudes and behaviour of the inhabitants towards mental illness; (c) the attitudes of families towards a sick member still in hospital.

The Audience Research Department of the British Broadcasting Corporation (BBC) carried out an inquiry into some of the effects of a television series "The hurt mind", broadcast in 1957. This series of five half-hour programmes in successive weeks dealt with psychiatry in a fairly comprehensive way. The inquiry was based upon the test-room performance of 800 people whose decision to view or not to view had been made without knowledge that an inquiry was to be conducted. The data obtained provided valuable indications regarding community attitudes towards mental patients.

The attention of the Committee was drawn to the fact that much more factual information might be obtained through the co-operation of public-opinion organizations which exist in many countries.

However, attitude research alone is likely to give too piecemeal and fragmentary a picture of the situation within a community and needs to be co-ordinated with the more general type of analysis made by the cultural anthropologists and sociologists. Their assistance is needed not only to obtain a better understanding of the varieties and causes of mental disorders in various societies but also in tracing the reasons for attitudes towards them. Only after careful consideration of the position of the mentally ill

within their own culture will it be possible for the social psychiatrist to develop rational preventive, therapeutic, and rehabilitative measures.

Some inferences about community attitudes can be drawn from the terminology used in referring to mental patients in different countries and within various community groups. Evidence in this respect was brought forward in connexion with French and American usage. A further indication is given by the terminology used in legislation. This is extensively dealt with in the chapter on terminology and definitions in the survey of existing legislation published by WHO in 1955.<sup>1</sup>

Apart from changes in terminology, the contents of legislation throw some light on attitudes of various communities towards mental patients. However, as pointed out in the fourth report of the Expert Committee on Mental Health,<sup>2</sup> legislation in many countries lags behind present mental health work and thus is possibly out-moded also as compared with existing community attitudes.

Arrangements made for the care of the mentally ill reveal something of community attitudes towards them. Examples are the extent to which mental patients remain in close contact with the community or are isolated from it in institutions, the type of institution provided, the extent to which the institution attempts to rehabilitate patients or remains a mere place of custody, whether prisons and police stations are used to house mental patients, etc.

A historical survey of attitudes towards mental patients in various countries may also increase understanding of present attitudes. Thus, the primitive belief in demoniacal possession as the cause of mental disorders is still widespread in some areas and has probably not been entirely superseded anywhere.

Although no survey has been carried out on literature and art as sources of information on community attitudes towards mental disorder, they are likely to prove a reflection of such attitudes.

## 2.2 Types of attitude

The above sources of information reveal a wide range of attitudes towards the mentally ill, extending from failure to realize that they are ill at all and full acceptance of them as members of the community, to complete rejection of those not conforming to the norm. Between these extremes are found attitudes of veneration, tolerance, pity, amusement, morbid curiosity, anxiety, fear, prejudice, repulsion, and hostility.

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<sup>1</sup> World Health Organization (1955) *Hospitalization of mental patients*, Geneva (Originally published in: *Int. Dig. Hlth Legis.* 1955, 6, 1)

<sup>2</sup> *Wld Hlth Org. techn. Rep. Ser.*, 1955, 98

Favourable attitudes may be based on family ties and may be supported by the community structure. Unfavourable attitudes may arise out of ignorance of the causes of mental illness and the unpredictable behaviour of the mentally ill, which threatens the community and creates anxiety. This is increased by myths about such illness. In fear and ignorance, man attempts to control anxiety by developing specific attitudes and behaviour which he considers appropriate. Recurrent emotional outbursts (of fear, for example), reinforce these new patterns; and so attitudes are made. Avoidance provides a most frequent and effective way of preventing anxiety. Thus, a community may attempt to keep as distant as possible from the mentally sick by building big isolated hospitals and by refusing to employ or be near former mental patients. The pleasure of acting out aggressive impulses based on prejudice subtly reinforces rejection of the mentally sick.

Although it may be supposed that the attitude to the mentally ill as patients in need of treatment is a relatively modern concept confined to areas with extensive psychiatric facilities, the Committee notes that in certain other areas of the world this attitude has been prevalent for centuries, as shown, for instance by the custom of sending patients to be treated by Buddhist monks or other religious healers.

An attempt will be made in the following sections to separate out the prevalent attitudes according to type of illness, community structure, social environment, and specific groups under consideration. It is stressed once again that the data assembled are far from complete. It is hoped, however, that a brief survey of present knowledge and opinions will assist in providing a framework for further research.

### **2.3 Factors affecting attitudes to different types of illness**

#### *2.3.1 Concepts of mental illness*

Several surveys have shown that members of the general public often have no clear idea of what constitutes mental illness or what varieties of mental illness exist. The Illinois study (p. 8), for example, showed that in the United States there are apparently two groups in the population whose knowledge of what constitutes mental illness is deficient: (a) people with an education of less than high school standard; (b) those over 50 years of age. In the NORC study (p. 8), those questioned generally distinguished between "nervous conditions" and "insanity", but included both as forms of mental illness. In another context, however, when the respondents were not giving a definition but were speaking spontaneously, they tended to slip back into identification of mental illness with psychosis only. Later in the interview, a series of six descriptions was read to the respondents; they were short case histories developed with the help of psychiatrists to

portray the following types : a paranoid, a simple schizophrenic, an alcoholic, an anxiety-neurotic, a compulsive-phobic personality, and a case of behaviour disorder in childhood. Only the extreme case of the paranoid received a high degree of recognition as mental illness. The conclusion was drawn that most people in the USA are aware that the definition of mental illness has been modified, but that they have not yet fully grasped the significance of this change.

In the BBC study referred to in section 2.1, persons who had not seen the television series were asked to state what were the different types of mental illness. About three-quarters of them referred to neuroses (generally using much less specific terms) ; about a quarter referred in a fairly unspecific way to paranoia, obsessional types of disorder, depressions and schizophrenia ; and fewer than one-tenth referred to psychopathic personalities.

Several inquiries suggest that there is a widespread tendency to divide mental patients into "those who should be shut up" and "those who are not really mad". On the other hand, it was noted in Nigeria that among the "Babalawo" (the so-called "witch-doctors" who actually combine the functions of healer and religious leader), there was resistance to the suggestion that it might be possible to distinguish between various forms of mental disorder.

### 2.3.2 *Concepts of origin of illness*

The concept of the origin of mental illness generally held within a community may profoundly affect attitudes towards the mentally ill. In one country, for instance, where sections of the population believe insanity to result from demoniacal possession, it is the devil that is hated rather than the individual, who is deserving of pity. Consequently, if the devil is driven out, the recovered person is completely accepted back into the community.

In some communities, mental disorders are reputed to be mainly of hereditary origin, and the remark is commonly heard : "It is in the family". This belief frequently leads to the assumption that mental illness has a poor prognosis, and to rejection of the person who has had a mental disorder as a suitable marriage partner, or to hostility towards him if he does marry for acting irresponsibly towards future progeny. In certain circles such hostility may be increased by the fear that inherited goods will be squandered. Such an attitude is reflected in special legislation regarding marriage, divorce and inheritance by the mentally ill.

Where it is believed that a mental disorder is of somatic origin, there is often a favourable attitude towards the sufferer, partly because of increased hope of curability and partly because he is then considered in some way as being less responsible for the weakness of will or of soul or of mind, which is sometimes taken as the cause of his abnormal behaviour. Those

individuals whose mental disturbance is supposed to originate from cranial trauma, from fatigue, or from the "nerves" are in general also better tolerated.

### 2.3.3 *Normality and abnormality*

Thinking, behaviour, and function considered to be normal in one culture may be considered as abnormal and even as signs of mental illness in another. Some types of African magical thinking, for example, would be considered hallucinatory in Europe.

As an example of different reactions to behaviour, "indecent exposure" as a symptom of psychiatric illness is meaningless and provokes no antagonistic social response from certain primitive communities, whereas it may arouse deep contempt and punishment elsewhere. Suicidal attempts may be considered as sacrificial consecration to the gods in one culture but meet with punishment in another.

Where the mentally ill individual is still able to carry out the functions expected by the community, the attitude towards him is likely to be favourable. Thus, the mentally retarded in a simple agricultural community will generally be well accepted.

"Fashions" in abnormality—such as Arctic hysteria or running amok, the dancing manias of the Middle Ages, passing addiction to different types of drugs—may influence the ways in which people will become abnormal. Fashion probably had something to do with differences between the kinds of neurotic disorder observed in the First and Second World Wars.

### 2.3.4 *Overt symptoms, prognosis and treatment*

Related to the questions of normality and abnormality discussed in section 2.3.3, is the role played by the patients' overt symptoms in influencing the attitude of the community. Patients who are aggressive or whose behaviour is a nuisance to the surrounding population are likely to arouse hostility, whereas quiet and withdrawn patients may be treated with pity or indifference. Of particular importance in this respect is the predictability of the patients' behaviour, since unpredictable behaviour provokes fear and rejection.

Real or supposed prognosis may considerably affect attitudes. Where the illness is considered to be curable, there is more likely to be acceptance of the sufferer, whereas the "hopeless" cases are apt to be rejected and isolated.

As a corollary, the types of treatment available are liable considerably to affect attitudes towards the mentally ill. Treatment by psychoanalysis, for example, tends to create in some environments an aura of fascination

around the mentally ill patient. Treatment by physical methods seems to be promoting a hopeful attitude and a better acceptance of the treated patient, who can thus be put on a par with the patient who has recovered from a physical disorder. Further considerations on the relation between attitudes and treatment are outlined in section 4.

## **2.4 Reaction to different clinical types of mental illness**

### *2.4.1 Psychotics*

Where "mental illness" tends to be equated with "psychosis", attitudes to the mentally ill are likely to be less favourable than if the term is taken to include the less serious forms of disturbance as well.

Because schizophrenics are so numerous, attitudes towards them will strongly affect consideration of the mentally ill as a whole. Indeed, this tendency seems to have been largely shared even by psychiatrists until recently, when new therapies began to be introduced. Among many communities, in fact, the label "schizophrenic" has become sinister, as indicative of an incurable mental condition. In some areas a diagnosis of schizophrenia may prevent entrance to university and may close the door to any responsible post. Intellectuals are apt to fear that if they have relatives who have been diagnosed as schizophrenic they will encounter professional difficulties. Such a diagnostic label is sometimes avoided by hospital psychiatrists in order to reduce the stigma for the patient on return to society.

### *2.4.2 Neurotics*

Although many communities have developed terms to describe persons showing mildly deviant behaviour, it would appear that frequently there is a desire not to categorize such persons or stigmatize them as mentally ill, so that they may be kept within the accepted group.

The neurotic is relatively familiar and ordinary people find it easy to identify themselves with him; in fact, in certain countries and levels of society, it has become almost fashionable to have a neurosis. Neurosis may even be equated with intelligence in the public mind. Where the symptoms exhibited by the neurotic make emotional demands on those around him, however, he tends to be resented and to be labelled a psychopath.

### *2.4.3 Psychopaths*

As yet the suggestion that treatment of the psychopath should be regarded as a medical problem has not found wide acceptance. The opinion that such individuals are merely anti-social nuisances and must be dealt with by restrictive and punitive measures to safeguard society is wide-

spread and is even held by many physicians. This attitude is now changing in professional circles. The Royal Commission report<sup>1</sup> on the new British mental health law stresses that the responsibility for treating psychopaths should be assumed by the psychiatrist. The layman, however, still finds it difficult to accept the view that such people, who often show a lack of sense of responsibility, an inability to learn by experience and, above all, an incapacity to realize the effect of their behaviour on others, should be considered as ill rather than evil.

An important aspect is that many people do not distinguish between those psychopaths who represent a real threat to the lives and safety of others and the more inadequate, harmless type of psychopath. Although the former constitute a very small proportion of the total numbers, their aggressive, delinquent behaviour creates undue alarm which influences people's attitude to those whose behaviour represents no serious threat.

#### 2.4.4 *The mentally subnormal*

It emerged very clearly from the Committee's discussions that the attitude of the community towards the mentally subnormal person depends very much on the environmental conditions to which the latter is expected to adapt. In communities where the work-expectation level is low, he is well tolerated and frequently his abnormality passes unnoticed. Where the level of education is higher, parents may feel shame or guilt at having mentally subnormal children, and the backward may find it impossible to get employment. In towns the need for the mother to stay at home and look after a retarded child instead of doing paid work, or the burden of having to feed an unemployed, mentally retarded adult may create attitudes of hostility. Where the public have been given factual information showing that retardation is very largely exogenous in origin, much of the stigma seems to be removed from the condition.

#### 2.4.5 *Abnormal children*

The feeble-minded or mentally retarded child is considered primarily as a human being in need of care, and the attitude is often one of pity. As a rule, care is considered as a task of both the individual and the community. The attitude towards children with behaviour disorders is in general quite the contrary. These children are frequently considered to be responsible for their behaviour, or are seen as moral defectives and not as patients in need of psychotherapeutic treatment. Psychotic children, many of whom have brain damage, need special care. However, the attitude towards them is in general one of rejection.

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<sup>1</sup> Great Britain, Royal Commission on the Law Relating to Mental Illness and Mental Deficiency (1957) *Report . . .*, London, H. M. Stationery Office

#### 2.4.6 *Abnormal persons of advanced age*

According to the teaching of many religions, elderly people bring blessing upon the household and the old person at home is to be respected and protected. This attitude, which applies both to normal and to mentally disturbed aged, still appears to be widespread throughout the East. Moreover, certain investigations have shown that it may be supposed that even where the three-generation family is being disrupted, the attitude towards the aged is not necessarily worse. Nevertheless, certain changes connected with industrialization appear to have increased the numbers of aged persons living in isolation or being placed in institutions for care. There are also indications that attitudes to elderly persons showing mental abnormality tend to become less favourable in cultures undergoing change, where the aged are less able and willing than the younger to adapt to the new ways of life. There is some evidence that attitudes towards the aged are closely related to social class, particularly in the more highly industrialized countries. This may be explained by the fact that the younger generation tends to be of a higher social class than their parents. The parents are accordingly an embarrassment and a handicap to their children. Some of the rejection which takes place in respect of the abnormal aged presumably arises from this factor. As shown in the report of the Expert Committee on the Mental Health Problems of Aging and the Aged,<sup>1</sup> such attitudes are now beginning to change and in many places there is a greater willingness among the young to collaborate in the treatment and rehabilitation of those older members of the community who suffer from mental disorders.

### 2.5 **Influence of community structure and community institution**

#### 2.5.1 *Rural and urban environments*

As already mentioned in several of the foregoing sections, the position of the mentally sick depends very much on the structure of the community within which they live. Thus, in a relatively agrarian society with extended kinship groups and fixed family rules, the mentally ill are usually accepted and supported by the family whereas, in rapidly changing and highly industrialized societies, such persons are more likely to be regarded as a burden, and to meet with rejection.

In many rural areas, a high percentage of the mentally subnormal and some psychotics are able to function fairly adequately and can live as tolerated members of the community. However, as rural areas are subjected to modern social and economic changes this attitude is changing. This is particularly true where technological changes are being introduced into

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<sup>1</sup> *Wld Hlth Org. techn. Rep. Ser.*, 1959, 171

agriculture, necessitating higher intellectual levels. There is evidence of a certain amount of hostility towards the "chronic" mental patient whose symptoms are not very apparent, but who refuses to work.

Certain conditions of urban life are apt to affect the onset and expression of mental illness. Thus the complexity of urban life calls for greater powers of adjustment than are necessary in rural areas. Cramped living conditions may have adverse effects and result in the mentally disturbed being more of a nuisance than under conditions of greater liberty in rural areas. On the other hand, there is generally a higher level of education among inhabitants of urban areas and this may favourably affect attitudes towards the mentally ill.

#### 2.5.2 *Socio-economic level*

Mention has already been made of the "snob value" in some circles of consulting a psychiatrist, and of the fear of genetic taint or loss of status in others. Where the mentally ill are not a financial or economic burden there is more likely to be a favourable attitude towards them. It is probable that in countries where mental disorders are covered by medical insurance there is less hostility towards patients than where treatment is a drain upon family resources; and in countries where insurance for the mentally ill is about to be instituted, it is expected that the status of mental patients will improve, in the same way as aged persons attained a better status when they began to draw pensions.

#### 2.5.3 *Community institutions*

Certain community institutions are of great importance for the formation and expression of community attitudes towards mental patients. Examples are organized religion, law, and educational systems.

Religious injunctions, such as those enjoining the family members to care for their sick and aged, will favourably affect attitudes to the mentally ill who are considered to be sick, although persons who are considered to be immoral or violators of religious codes are likely to be rejected. In many areas, religious leaders and organizations have traditionally cared for the mentally as well as the physically sick.

While attitudes of a community are not without influence on the laws of the corresponding society, the existing law also influences community attitudes.

In some countries, the main concern in framing the laws on psychiatric matters is to safeguard the rights of the individual on the one hand, and to protect the interests and property of the community on the other. This has led to the inclusion of provisions that are very cumbrous, such as the need to satisfy a non-medical magistrate of the reality of the patient's

illness, or to prove insanity in a court of law. In other societies, mental health laws are biased in favour of protection of the rights of the community, and may cause severe deprivation of the mentally sick person. Such provisions must inevitably lead the public to associate punishment and seclusion with the mentally ill. Where the law is more closely concerned with ensuring adequate treatment and care and where provisions are made for voluntary admission to mental hospitals, the community is more likely to consider the mentally ill as patients in need of treatment.

The educational system is likely to influence community reactions to those suffering from mental disorders. The attitudes of the teachers will depend to some extent on the training they have received. In some areas, this training will include study of the psychology of education, with basic information on normal and abnormal personality development. Such training should help the teacher in his understanding of the abnormal child, and should also exercise a salutary influence on public opinion in general.

Other media—the press, literature, radio, television, and films—are likely to provide education (which may be good or bad) on abnormal mental conditions. A positive influence is shown in the BBC study, but it would be possible to quote instances of detrimental effects.

## **2.6 Factors affecting individual attitudes**

### *2.6.1 Age and education*

Within the social groups referred to there are certain factors causing differences of attitudes between individuals. One such factor, age, is closely linked with education, as shown in the Illinois Study already mentioned. When a group of people over 50 years of age was matched with a group of younger people of similar educational standard (high school) it was found that there were still differences between the age-groups as regards ideas about the mentally ill, their treatment, and their reception back into the community. Such differences are less likely to be found in the more stable agrarian communities.

### *2.6.2 Personality factors*

A person's attitude towards the mentally sick is often strongly conditioned by his personality. Those who, because of their psychological make-up, tend to discriminate against other human groups (because they belong to another sex, race, religion, nation, etc.) frequently also show a rejecting and hostile attitude towards the mentally ill. Evidence for this has been found by carrying out tests with the so-called F-scale which is claimed to indicate tendencies towards group discrimination.

## 2.7 Attitudes of specific groups

### 2.7.1 *Family*

There are indications that in some communities attitudes to the mentally ill within the family group are more negative than to those outside. In one study it was found that words like "insane man" or "insane woman" had a negative rating. It was also found that words like "father", "mother", "sister", and "grandmother" had a positive rating, "mother" having the most positive rating of all. When the concepts were mixed, however, "insane mother" was found to rate lower than "insane woman". This was the lowest kind of connotation, as though the public were saying "a mother has no right to do this to a child".

On the other hand, the attitude of parents and siblings towards a mentally ill person in their family is often very sympathetic. One example is that of mothers deeply devoted to their subnormal children. Conversely, there are children devoted to and caring very well for their mentally abnormal parents.

### 2.7.2 *Community leaders*

A recent study carried out in the United States of America revealed that on a number of issues people in positions of leadership in the community—the mayor, members of the city council, ministers, teachers, etc.—had more liberal attitudes, were more tolerant and less rigid in their views, than the general public. This might not be true everywhere. Nevertheless, since the attitudes of the leaders will be influential in the organization of a programme of social psychiatry, it will be important to be aware of them.

### 2.7.3 *Employers*

Obviously the type of mental disorder and the nature of the symptoms will affect the attitude of employers and fellow workers towards mentally ill persons. There is, however, a tendency towards increased tolerance. In communities where there is a growing public acceptance of psychiatric treatment, certain employers even allow patients time off to attend treatment sessions, in much the same way as they would for a physical illness. In at least one hospital, patients who are clerks are encouraged to move their work to a nearby branch office so that treatment can be continued and the offices concerned have been prepared to co-operate in this way. Another hospital, which specializes in group treatment, has among its patients highly educated and capable men who regularly attend group sessions outside working hours for periods extending up to several years without in any way jeopardizing their security.

#### 2.7.4 *Medical and other health personnel*

The attitude of the general medical practitioner towards psychiatric patients will depend to some extent on his training in psychiatric subjects and to some extent on his experience of the possibilities and results of treatment. Increased interest in the psychosomatic aspects of medicine is liable to produce more favourable attitudes to the mentally ill. Where there are facilities for the treatment of mental patients in general hospitals, in out-patient clinics, and in the community, the general practitioner is likely to have a more realistic attitude to the mental patient compared with situations where such patients are relegated to large, isolated mental hospitals.

The attitudes of the nursing staff to mental patients will inevitably be affected by their training and by the treatment and regime in the hospital or service within which they work. It is being increasingly realized that the nurse requires, above all, an understanding of the causes of the patient's behaviour and how to deal with it in a therapeutic manner. Where the nurse acts as a member of a therapeutic team, she is in a better position to acquire such an approach. It is equally important for the nurse or social worker who carries out domiciliary work to have a favourable attitude towards the patient, derived from an understanding of his condition.

#### 2.7.5 *Patients*

The community attitude towards the mental patient will inevitably affect his attitude towards himself. Where such patients are rejected by the community and feel afraid and ashamed of their condition, they are more likely to suffer from loss of self-confidence and self-respect. It has been clearly demonstrated among formerly noisy and unmanageable patients that removal of restraint, increased freedom, and relative increase in responsibility lead to greater self-respect and improvement in behaviour, which in time may favourably affect community attitudes. This may be particularly evident where the patient's family is involved in the treatment process.

### **3. COMMUNITY ATTITUDES AND PSYCHIATRIC PRACTICE**

#### **3.1 Attitudes to treatment facilities**

Whether or not the community is prepared to co-operate with the psychiatrist depends to a large extent on the esteem in which psychiatric practice is held. Where the opinion prevails that the psychiatrist and his collaborators have no other function but to keep social deviants out of

harm's way and preferably under lock and key, the community will have little motivation to co-operate in an active way. Where, on the other hand, the community believes that the goal of psychiatric practitioners is to help their patients to regain and maintain their personal and social adequacy, the community will be far more prepared to go into active partnership. It must be admitted, however, that there are also other public opinion trends. Where the community fears that the psychiatrist and his collaborators are likely to jeopardize its security it will tend to build up its own protective devices. Where, on the other hand, it is confident that the psychiatric practitioner cares as much for the public weal as for that of his patients, it will look on his activities in a spirit of helpfulness.

Here again considerable differences are noted in different cultural surroundings. In some parts, it is relatively easy to obtain the approval of the community for non-institutional care of all types of mental patients. In one part of Nigeria, for instance, where many people have a horror of hospitals, regarding them as foreign institutions, unrelated to their traditional background, it was possible to institute a system of treatment within local villages without arousing major resistance. The co-operation of the local inhabitants was first secured. Patients coming for treatment are accompanied by at least one member of their family and live in the homes of the villagers. The hospital staff go into the community to give treatment, although intermittent specialized care may be given in the hospital. Patients are free to return home when they wish. Elsewhere a lengthy process of adjustment was necessary before the community was ready to accept the procedures of social psychiatry.

Particularly in countries where the population has been accustomed to mental patients being locked up in closed institutions, it was necessary to convince people of the effectiveness of modern psychiatry. A case in point is the great change in this respect that has taken place in recent years in Great Britain, and also in many other countries where a re-orientation of opinion has been achieved. There are today many new facilities, amongst which the day hospital, the night hospital, the psychiatric ward in the general hospital, and the out-patient department should be mentioned; all of these can now count on a great deal of public support, mainly because they have proved to be practicable and useful apart from being desirable from the humanitarian point of view.

One indication of changing attitudes is the almost universal revision of terms applied to institutions for the mentally ill. In many languages, the equivalent of "mental hospital" has replaced "madhouse" or "lunatic asylum", terms which had fallen into disrepute as referring to places of custody. Another reflection of the changes is the extent to which the mentally ill now voluntarily apply for admission to psychiatric hospitals. The few available statistics show that in the United States of America in 1949 approximately 10% of admissions to state mental hospitals were

voluntary ; in France, in 1952, 31% of mental patients had entered hospital voluntarily, and in England and Wales the figures were nearly 70% in 1952 and about 90% in 1957.

The psychiatric hospital is beginning, then, to be looked upon like the general hospital as a place for treatment rather than a place for custody and detention. Advances in diagnosis and treatment have enabled the modern mental hospital to admit patients at a much earlier stage of their illness than formerly, so that prognosis is apt to be better and the patient is more quickly able to return to the community. There is evidence of an increasingly hopeful attitude among the community towards the possibility and efficacy of treating mental patients, as shown in the *Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency* :<sup>1</sup>

“ An increasing number of people have friends or relatives who have been patients in mental hospitals, most of whom have spent a few weeks or perhaps months under treatment and have then come home to resume their normal lives, and first-hand knowledge of the mental hospitals and what they are doing is spreading in this way . . . Indeed, we believe that most people today would at least pay lip-service to the principle, which has been repeated to us by witness after witness, that the mentally ill are sick people and that the mental hospitals should be thought of primarily as hospitals for the treatment of illness.”

As a concomitant of improved understanding and treatment of mental disorders, it has become possible to organize mental hospitals as “ therapeutic communities” (see Third Report of the Expert Committee on Mental Health)<sup>2</sup> and in some hospitals to dispense entirely with locks and bolts.

Where such an experiment has been tried great opposition has often been encountered, even from members of the staff. Gradually, this attitude has changed and it has become increasingly realized that in open wards patients become less rather than more troublesome and the incidence of escapes is reduced. As stated by a sister in an Eastern Mediterranean country after three years of experience in an open ward :

“ Patients do not feel they are in a prison. They feel they are in a place to be treated and cured and not punished. When patients are given freedom they gain confidence in themselves and they can achieve an astonishing improvement in their attitude and in their behaviour with increase in confidence in the hospital. They are far more ready to show the co-operation that is always desirable between the patients and the staff. They seem to become more capable of arranging things by themselves. The patients gain a sense of independence and confidence which helps them to overcome the feeling of inferiority to which so many of them are prone.”

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<sup>1</sup> Great Britain, Royal Commission on the Law Relating to Mental Illness and Mental Deficiency (1957) *Report . . .*, London, H. M. Stationery Office

<sup>2</sup> *Wld Hlth Org. techn. Rep. Ser.*, 1953, 73

As regards the reactions of the community to open-door hospitals, it has been found that after a trial period the community (if aware of the change) reacts in the same way as the staff, and the opening of wards tends to be well received. Mention was made of such a hospital in Central America where the hall formed a kind of public thoroughfare where public and patients mixed freely and boys played football to the enjoyment of patients and visitors alike. Another instance of improved acceptance of mental patients by the community was a hospital in Europe where the cinema was shared by the surrounding inhabitants. Many other methods have been tried for introducing the community into all parts of their local psychiatric hospital so that mental patients should become more familiar to them and should be less cut off from the community life, and this has given good results. Inquiries in an area of the United States of America, however, revealed that while the public considered open-door hospitals to be fine in the abstract, they were doubtful about the desirability of such a practice in their own environment.

In Britain a number of "neurosis centres" have been established for the more serious cases of neurosis and for some early psychoses that have never come within the Mental Treatment Act. At these, there are no formalities whatsoever for in-patient treatment; such centres seem to invoke less public prejudice than psychiatric hospitals and many people are more ready to accept treatment in them.

The treatment of psychiatric patients through out-patient facilities is by no means new but is receiving renewed emphasis, as in the Nigerian experiment mentioned. In the small town of Gheel in Belgium it has been the tradition for 1200 years for a high percentage of families to accept responsibility for mental patients in their homes. They do not fear them, nor the consequences of their behaviour, and patients with serious mental disorders mingle freely in the community. Periodic care and treatment are given by the staff of the small hospital and patients may be taken into the hospital for short periods. A similar situation is found in the Seine colonies in France, and elsewhere.

The system of foster-home care, which is used in many countries, makes it possible for patients to adjust themselves to life within a family even when their return to their own families is for some reason impossible or inadvisable. Experiments have also been carried out with hostels for mental patients recently discharged from hospitals. Some of these patients are placed in sheltered workshops where they are gainfully occupied under the guidance of a specialized staff. The working village which has been set up for patients predominantly from rural areas and which has proved very successful in some countries, such as Israel, constitutes a parallel approach. Services which aim at treating the mental patient as far as possible in his own home with simultaneous attention to the family situation and environmental causes of breakdown have been developed in other parts, for

example, in the Netherlands and particularly in the city of Amsterdam.

The above examples show that there are possibilities of successfully treating patients in a community less restrictive than that of the mental hospital. However, such care does not necessarily eliminate the problem of reintegrating the improved patients into their own community; the active co-operation of the population must also be ensured. In many cases, attempts to bring about closer contacts between mental patients and the community have at first encountered resistance, but as the population became accustomed to the presence of patients in their midst, they gradually became less afraid of their reactions, and accepted them more readily.

In a number of countries, out-patient services have been considerably extended in recent years. The introduction of modern therapeutic techniques—psychological as well as somatic—has done much to improve care on an out-patient basis. In an attempt to reduce the admission rate to mental hospitals by providing expanded facilities for out-patient and domiciliary treatment, a two-year controlled experiment was carried out in a precisely defined area in Britain, the activities in the same area in 1956 serving as a control. In that year the admission rate to the mental hospital for the area was 82.3% higher than in 1950. During the first six months of the experiment, in 1957, the admission rate was reduced by 60% compared with the same period in 1956. However, this was only one of the aims: the other was to provide adequate and effective treatment, and this is believed to have been achieved. Another notable example of out-patient care is the extramural psychiatric service founded in 1930 in the canton of Valais in Switzerland. The services are itinerant and reach the smallest village in the canton.

However, since modern psychiatric out-patient services are not limited to the treatment of minor psychiatric disease (neuroses, behaviour disorders, etc.) but cater largely also for psychoses, there was much public resistance to their creation in the beginning. It has been the experience of most observers that this resistance decreased once the usefulness of the work done was recognized by the population, and nowadays the good done by such out-patient services and the need for their existence is in most parts no longer disputed. In fact, it can be said that efficient out-patient services have greatly contributed to the reduction of hostile and rejecting attitudes in respect of psychiatric activities. It seems to be the general experience that the psychiatrist and his staff are the more easily accepted and appreciated the more they participate in out-patient work.

Some investigations have been carried out on the reactions of society to patients who, while still mixing freely with society, are receiving treatment for mental illness at an out-patient department. In the BBC study (see p. 8) nearly 90% of those questioned agreed with statements suggesting that they would feel sympathetic towards such patients and wish them

well; 10%-30% agreed that they would feel a certain amount of fear or uneasiness, or that they would not feel able to trust such persons, even though they were supposed to "seem all right" and be "as pleasant as anyone else". About three-quarters of the respondents indicated that they would be willing to mix freely with mental patients in such circumstances, but fewer than half that they would be willing to employ them.

### **3.2 Attitudes to various types of psychiatric treatment**

#### *3.2.1 Somatic treatment*

The more hopeful attitude of the public to psychiatric treatment is due to some extent to the remarkable advances in the somatic treatment of mental disease made during the last few decades. This is not merely because such treatment bears a similarity to that used in general medicine; even more significant is the fact that treatment by drugs, electricity, artificial fever, etc., is in many cases patently and often quickly successful. Another factor is that somatic therapy is more easily understood than psychotherapy; at all events it is an observed fact that such treatment is often preferred and even demanded by the less sophisticated sections of the community.

#### *3.2.2 Psychotherapy*

While psychotherapy has for many people an aura of magic, it has nevertheless been the predominant factor in the improvement of people's attitudes towards psychiatric practice.

In some agrarian communities, local healers appear to have a certain understanding of the rationale of psychotherapeutic practice and the population shows a willingness to submit to their powers. In a few areas, an attempt has been made to graft medical psychotherapy on to the practices of traditional healers with religious backgrounds. Where this has been done prudently, it has added to the prestige of psychiatry and has helped to create favourable attitudes in the community towards psychiatric treatment.

As already mentioned, psychological treatment by a psychiatrist in private practice does not necessarily stigmatize a patient and may, in fact, have a "snob value" in certain circles.

#### *3.2.3 Social therapy*

Reference has already been made to the gradual transformation of psychiatric institutions and to the fact that the work carried out in them is approaching more nearly the ideal of a socially integrated treatment of personality disorders. The fact that psychiatric patients have been proved capable of functioning in a socially acceptable way has undoubtedly been of great importance in modifying the attitude of the community towards

psychiatric practice. Special reference should be made in this connexion to the role played by occupational therapy or, as some prefer to call it, therapeutic occupation, inside and outside institutions.

#### 3.2.4 *Occupational therapy*

Occupational or work therapy has been increasingly used in western cultures, not only as a graduated therapy for mental disorders, but also as a means of keeping the patients in closer contact with the community. On the whole, the public would appear to approve of this type of treatment as long as there is no question of competition with outside workers or conflict with trade union regulations. Some communities consider that payment should be made for patients' work: in some cases this is done with the object of providing an incentive similar to that existing outside the hospital.

The structure of a society may affect the attitudes of patients and of the community to work therapy. In some areas, wealthy patients are more reluctant to work in hospital than are the less privileged classes. The nature of the work provided must take these factors into account. It should be remembered that in Europe and America work is generally considered to be a good thing. In other parts of the world, this is not necessarily so: work, and especially manual work, tends in some places to be equated with low social status. It follows that work therapy has not the same significance in these countries. There is evidence, however, that in some areas psychiatrists have managed to overcome such resistances.

### 3.3 **Rehabilitation and employment of mental patients**

There are two different classes of patient being discharged from the mental hospitals today. In one class, there is the chronic patient whose illness has been of long duration, possibly many years, but whose case has now become susceptible to modern treatment; even if not restored to full health, he has reached a stage where continued residence in the mental hospital is no longer necessary. In the other class is the subject of an acute breakdown, who has responded quickly to treatment and who has spent only a short time in hospital.

The long-term patient is coming out into a world that he has forgotten and which, more often than not, has forgotten him. In industrial areas, the whole tempo of life has quickened in his absence. Whole districts have been rebuilt, landmarks familiar to the patient have disappeared, and strange new buildings have taken their place. Industry has altered considerably. One-time staple industries have declined in importance and completely new forms of industry, requiring new skills, have been established.

The patient requires guidance into this new and unfamiliar world and needs to be taught how to live in it. He will find the speed of life bewildering,

and even if he still possesses the work skills with which he once earned his living, he may well find that there is now only a limited field for such skills, or even none at all. He will have to be fitted into an entirely new and unfamiliar employment pattern. He will not only need teaching and guidance, but considerable support during his initial bewilderment.

In addition to the factors already mentioned, there will be the question of re-establishing satisfactory personal relationships. In many cases, the family will have disintegrated during the time the patient has been in hospital; he will have been forgotten by one-time friends and workmates, and he will have left his more recent human contacts behind him in the hospital. For the moment he stands alone. His natural tendency will be to run for cover—back into the mental hospital.

The short-term patient has entirely different and, in one sense, reverse problems. He is perhaps too well remembered and his own memory of events around the time of the breakdown are too vivid. Very real difficulties may spring from these facts. There may have been some dramatic or even violent incident associated with the breakdown. The family and the community generally may fear his return and may not be prepared to accept him. He himself might be diffident about his return because he fears rebuffs.

A study carried out in two Canadian towns in 1951 included investigations on a social-distance scale to show how close a relationship the respondent was prepared to tolerate with someone who had been mentally ill. More than 1500 people were questioned. About three-quarters of the people showed willingness to mix with ex-mental patients at work or in a club; fewer than half appeared willing to share a room with such a person, and about three-quarters agreed that they would strongly discourage their children from marrying anyone who had been mentally ill.

A second study from the United States of America also stresses that the tolerance the patient finds in his environment decides whether or not he can stay out of hospital. The investigators found that patients living apart from their families returned to hospital more frequently than those who were at home. However, the opposite has been noted in a British study. The social group to which a patient returns is apparently more significant where long-stay patients are concerned; among early cases the patient's age, diagnosis, and length of stay in hospital are of greater importance.

Comcomitant with efforts directed at reintegrating the mental patient into his former environment, social psychiatry is concerned with fitting him into a work environment.

The first steps are taken while he is still undergoing treatment by seeking the active collaboration of the patient in understanding his role in the process and in learning how to adjust to employment conditions. It may be necessary to reintegrate a discharged patient into a work atmo-

sphere by gradual stages as, in some cases, a former patient can work satisfactorily only in an adjusted environment, which makes allowances for his handicap.

The problem of employment of psychiatric patients on leaving hospital is often difficult. All that has been said previously about the attitude of society to mental patients is relevant here. Much will presumably depend upon the symptoms which the patients manifest on discharge : for instance, someone showing evidence of uncontrolled behaviour would probably be less acceptable than a patient who quietly hallucinates ; but the mere fact of having been a mental patient may be enough to prejudice the employment prospects. In some countries, social organizations and legislation protect the mentally disabled as they do the physically disabled. Thus, in Britain 3% of all places in factories employing more than 20 men are reserved for disabled persons. In the same country, a vast rehabilitation scheme under the Ministry of Labour provides equal opportunities for the mentally disturbed and for physically disabled persons. There are almost one hundred factories for the severely disabled who cannot compete on the open labour market, and the fourteen industrial rehabilitation units run by the Government take many mentally ill patients while they are still in hospital. Rehabilitation of such patients is as satisfactory as in the case of the physically disabled. Similar systems are to be found in many other countries. However, the success of all these measures will in the end depend on the people with whom the more-or-less recovered patient is expected to associate.

Where a former mental patient is expected to return to non-sheltered employment, his success will depend to some extent on the attitude of the employer to the fact that he has been under treatment. Such individuals appear to be better accepted in the less highly technical, less responsible, less dangerous types of employment.

About half the respondents in the BBC study (see p. 8) showed willingness to employ mental out-patients and about 65% appeared willing to employ ex-patients from a mental hospital. However, only about one-quarter of those questioned seemed willing to employ an ex-patient in an important position.

There is evidence of improvement in the attitudes of both employers and fellow-workers to the former psychiatric patient in many parts. Unfortunately, however, there are signs of a diminution of acceptance in some of the developing countries where previously integration of the mentally disturbed into the community was often highly satisfactory.

#### **3.4 Attitudes to psychiatric personnel**

There are indications that just as attitudes towards the mentally ill improve with the realization of possibilities of treatment, so do attitudes

towards the psychiatrists, once their role as therapists is understood. Nevertheless, it would appear that in many areas there is still considerable prejudice against and fear of those who deal with mental illness. In western societies, this attitude probably has its roots in the feeling of helplessness and hopelessness which pervaded many of the custodial hospitals at the beginning of the century, and which affected all levels of the staff, as well as the patients and the general public. The impression that psychiatrists may be infected by the "craziness" of their patients still seems current in some areas. The fact that even now the mental hospital psychiatrist often has no contact with the world of the patient outside the hospital tends to maintain public prejudice and misunderstanding.

It appeared from the Illinois study (see p. 8) that the public holds only a moderately favourable opinion of people who deal with mental illness, that is psychiatrists, psychologists, social workers, and even mental hospital attendants. A much higher valuation is placed on those who treat physical illness, that is, on other doctors. It was found, for instance, that the word "psychiatric physician" had a higher positive rating than did the word "psychiatrist".

Some interesting data on the community's confidence in the ability of medical men to cure mental illness is derived from the BBC study. The following figures are for the control group which had not seen the television programme "The hurt mind". First, as to changes of a general nature, nearly half the group selected the statement that "there has been great progress" in the last twenty years. More than 70% felt that the majority of the mentally ill can be cured and the same percentage were fairly confident that psychiatrists and other medical men treating mental illness "know what they are doing". Only 22% showed a really high degree of confidence.

The Committee noted that in Nigeria the "Babalawo" treats physical as well as mental disorders and makes relatively little distinction between "organic" and "psychogenic" disease, so that the tribal Africans concerned are likely to have a unified psychosomatic concept of medicine. This attitude would seem to be favourable for the acceptance of the psychiatrist, particularly if he proves to be able to attend not only to the mental but also to the physical complaints of the patient. Such a qualification has also been found of advantage for the acceptance of psychiatrists elsewhere.

The development of psychiatric departments in general hospitals, and of out-patient clinics, day centres and domiciliary services is probably largely responsible for making psychiatrists more familiar to the general public and for removing some of the fear of the psychiatrist. The closer contact of the general physician with the psychiatrist in the general hospital is usually also helpful in overcoming the prejudices of the former against the latter.

#### 4. RECOMMENDATIONS FOR ACTION

In the preceding sections, attention has been drawn to many points on which knowledge is still incomplete. Obviously, much detailed research is required to ascertain prevailing attitudes of the community, to what extent various attitudes are favourable or unfavourable for the purposes of social psychiatry, and what measures would foster favourable community attitudes. Under these circumstances, it might seem that no action should be considered more urgent than research on these questions.

The Committee is indeed convinced that research is essential. Section 5 of the report will deal with some of the more important items to be considered. However, action cannot be delayed until all obscurities have been removed; certain activities must be based on such knowledge as can be acquired in the daily experience of the psychological and psychiatric practitioner. It is quite possible, therefore, that some of the proposals for action made in this report may later have to be modified, particularly in respect of the emphasis to be given to different aspects. The Committee consider, however, that it is possible now to formulate broad general principles which are at least dependable enough to serve as a useful guide to the planning of an effective campaign directed at changing community attitudes.

##### 4.1 Extension of active treatment and community care

As has been pointed out earlier, advances in psychiatry which have led to earlier detection, more and better possibilities of treatment, and more favourable prognosis appear largely responsible for improvements in community attitudes towards mental patients. As increasing numbers of the community come into contact with patients who have been successfully treated, attitudes based on fear and hopelessness are likely to be superseded. It therefore follows that a basic necessity for improving community attitudes towards mental illness is an extension of active treatment facilities closely linked with the community. The two processes are thus seen to be interdependent: better treatment leads to improved acceptance of the mental patient, and increased public tolerance is needed for further advances in social psychiatry.

An important principle to be kept in mind is that specialized activities in the field of mental health should be integrated, or at least closely coordinated, with other general health services. Thus, treatment for the mentally sick should be made available in the same way as specialized treatment for the physically sick. This should help to convince the public that mental illness is just as susceptible to treatment and cure as is physical illness.

## 4.2 Information and education

Of primary importance in a campaign aimed at changing community attitudes is the imparting of information. Precise information must be available on the nature of mental disorder and on the social circumstances which are significant in its genesis as well as in its treatment and prevention. A more widespread awareness is required of the possibilities of psychiatric practice in all its forms and of the value of adequate handling of social conditions and of support through social contacts beyond the immediate area of influence of the psychiatrist, both for persons who are in danger of falling ill, and for those who have already fallen ill. Obviously such information can only achieve the desired results if the community realizes that it has an important role to play and that more than goodwill and kind intentions are required of it. For this reason, it is essential that those who impart information—in the first place, the psychiatrists themselves—should not remain in the detached position of specialists talking down to the supposedly uninformed, but should rather show a willingness to learn what sort of information is most urgently required and how their knowledge is related to that of the public, that is, to what extent they share or reject the viewpoints held by the community.

### 4.2.1 *Techniques*

There are, of course, many ways in which information can be imparted. Among the media that are limited to what might be called straight information, mention may be made of the distribution of brochures and leaflets, the holding of popular lectures, and the provision of informative material through the press, the radio, and by television. However, it must be emphasized that long and patient effort and continued re-evaluation of method are required if public attitudes are to be favourably changed by these means. In the BBC study already referred to (p. 8), it was found that seeing the television programme was followed by some increase in viewers' knowledge of the subject, their confidence in the ability of psychiatrists to cure mental illness, their willingness to associate with patients or ex-patients, their readiness to think of mental patients in similar terms to other patients, and their insight into the existence of a social problem in respect of mental illness. On the other hand, resistance to educational programmes may be great. In a controlled study of two Canadian towns, one was subjected to an intensive programme of mental health education covering a period of six months. A subsequent attitude survey showed no significant change in public opinion. There are many instances to prove that statements in brochures and lectures which seem to be completely unequivocal to their authors easily lend themselves to gross misunderstanding and misinterpretation, and that the viewers of films often draw

wrong conclusions, which may even be the exact opposite of what was intended, although the material is presented in a manner that is apparently quite convincing.

Much of the information which is imparted does not achieve its purpose because the informant is not fully aware that information cannot simply be added to previous knowledge, but must be integrated into the whole system of knowledge, convictions and beliefs of people, taking into account not only the intellectual but also the emotional, and therefore often unconscious, aspects of the personality.

One point which has to be taken into consideration here is the need for a precise and careful choice of words. It is important not only to avoid equivocal and traumatizing terms but also to use language which has a ring of familiarity to those to whom it is addressed. This is one reason why it is preferable not to address information to the public at large, but rather to smaller groups composed of persons who have something in common upon which the informant can base his strategy and tactics.

An awareness of local conditions, cultural and otherwise, is indispensable for good mental health education. Moreover, it is necessary that the educator should have sufficient knowledge about the dynamics of personalities and groups. In other words, those who try to change community attitudes should take into account many of the theoretical and practical achievements of psychotherapists and social scientists.

The Committee therefore considers that the task of informing the public about psychiatric matters and creating a greater awareness of the role of the community can be accomplished more satisfactorily by the use of personal techniques than by relying on "straight information".

One efficient method is to stimulate discussion of the topics concerned. In some environments, it has proved useful to prepare public opinion by the provision of suitable background material which can then be discussed in freely-formed, unstructured groups. An example of such a procedure in the United Kingdom would be the preparation of a report of a Royal Commission, which is published, amply discussed in the press and by the public, and these discussions taken as a basis for further action by the authorities. In other areas, it may prove useful to assemble specific groups and discuss matters with them. Such group discussions sometimes function in a way closely related to group psychotherapy sessions. This is particularly so where unconscious motivation plays a significant role in the production of unfavourable attitudes. It is often found that those who tend towards discrimination in general and who consequently discriminate against mental patients or other persons of socially inadequate or anti-social behaviour exhibit an improvement in their attitude as a result of the "group process". Such a result presupposes, of course, that the educator has a certain knowledge of group processes and group psychotherapy techniques, a subject about which more will be said later.

The arranging of "open days" in psychiatric establishments is often very helpful. It may perhaps be said that the benefits of "opening" hospitals derive almost as much from allowing people to come in as from allowing others to go out. Undoubtedly there is no better way of showing possibilities and needs than demonstrating that good work is being done and better work could be done if every help and support were forthcoming from those who can give it.

There is probably no better means of spurring people into action than giving them an opportunity to identify themselves by their own activity with the task to be undertaken. In making this statement, the Committee not only envisages the possibility of using voluntary helpers in psychiatric situations, it also refers to the usefulness of bringing the families of patients into participatory action even at the stage of diagnosis. But participation in action is also valuable for changing the attitudes of other groups particularly those who by their leading position in therapeutic work or in the community at large could do most to improve community co-operation. Reference should be made at this juncture to the fact that not only doctors and nurses but also the patients themselves are often able to play a better role in therapeutic and preventive action if they are sufficiently involved to be fully identified with their task and fully prepared to play a significant role.

It must, of course, be admitted that adequate information is not always acquired only by what might be called a democratic process and within what have been styled "peer" groups,<sup>1</sup> particularly where unconscious and pathological motivations are responsible for discriminatory ideas and attitudes. It should be remembered that discriminators are often characterized by a high degree of conformity to authoritative rulings. Therefore, better attitudes are sometimes also brought about by ordering change through the medium of law and administration, or at least by ordering change on a small scale in a pilot project which may then be used for demonstration purposes. It has been observed that prejudices are often not held individually, but maintained because the individual believes that others have insurmountable prejudices which it might be better to leave undisturbed. This phenomenon, sometimes called "pluralistic ignorance", may best be overcome by well-timed, authoritative intervention. However, such a technique of facing people with an accomplished fact is fraught with many dangers and should not be used without circumspection. Generally speaking, circumspection is, of course, a prerequisite of all techniques to be used. Therefore it may often be useful not to go into large-scale action without having done a certain amount of pre-testing and evaluating of the results of trial runs. This, however, is already leading into the field of research.

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<sup>1</sup> Groups in which all participants are held to be equal.

#### 4.2.2 *Potential educators and their training*

##### 4.2.2.1 *Medical and other health personnel*

If the potential educators are to assist effectively in changing and improving community attitudes towards the mentally ill, they will obviously require proper training for their task.

There seems to be a general principle involved in the training of personnel in the mental health field, which centres on the concept of personal emotional involvement on the part of those undergoing training. The skill required is the teacher's capacity to create feelings of security in the group so that each trainee feels safe to express his feelings without restraint. In this climate, the difficulties in inter-relationships between the trainee and, say, the patient are used as the material to teach from.<sup>1</sup> This evaluation and understanding of subjective difficulties can be used to teach the individuals in the group something of their own emotional responses and ego defences, as well as such concepts as transference and counter-transference which cannot be understood adequately unless subjectively experienced.

(a) *Psychiatrists.* With the extension of social psychiatry, the psychiatrist is coming increasingly into contact with the community, through out-patient departments, psychiatric wards in general hospitals, and domiciliary visiting. Consequently, he will be able to play an important educational role, especially if, through his training, he is in a position to understand many of the reasons for prejudice against mental patients, and therefore to assist in counteracting such attitudes. It is of great importance that the psychiatrist should not direct his energies exclusively to applying his skills to the treatment of patients, but should devote a proportion of his time to improving the skills of the less highly trained but more numerous mental health workers, including nurses, social workers, probation officers, etc., who contact a much larger patient population and indirectly influence a much larger public. It is to be hoped that as the role of the psychiatrist for preventive as well as therapeutic work becomes more apparent, he will be more frequently called upon by administrators to advise on mental health aspects of planning—for example, in schemes for community development, or in preparation for industrial change.

Psychiatry has made so many important advances in recent years that the training of psychiatrists themselves is in need of re-evaluation. The

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<sup>1</sup> In at least one hospital, attempts have been made to use the patients themselves as educators. This is done through a weekly visitors' seminar where volunteer patients, staff, and visitors discuss social psychiatry as an unstructured group. The danger is, of course, that the patients' feelings may be highly subjective and bear little relation to reality. Where treatment has been good however, the patient may have an educational influence on those with whom he comes in contact.

Committee noted with satisfaction that proposals have already been put forward for WHO to carry out studies on this subject and on the place of the social sciences in the training of mental health personnel.

(b) *Psychologists and social scientists.* As has been pointed out before, these two groups of scientists will have a particularly important task in connexion with the investigation of prevalent areas of ignorance in relation to mental illness and the establishment of, and advice on, educational methods. The social psychiatrist will have frequent recourse to their skills.

(c) *General physicians.* Hospital physicians, public health doctors, and perhaps most of all general practitioners are likely to have extensive opportunities to assist in community education on mental health matters. The influence of the general practitioner will be of particular importance for the individual patient who seeks assistance, and for his family. In several countries, the mental health services now rely very largely on the family doctor to assist the community in realizing when treatment is necessary, what are the possibilities of success, especially of early treatment, and what type of treatment is available, and they also look to him to persuade patients to seek treatment voluntarily.

In many areas, the family doctor has little or no training in psychiatry, although in some countries this subject is now gaining in importance in the undergraduate medical curriculum. Much can be done by affording post-graduate training facilities. The doctor in practice soon comes to realize the importance of mental health and how insufficient is his knowledge of this subject, and he will have a strong desire for further education. Successful training of general practitioners and also of social workers on group lines has already been carried out in some countries.

(d) *Community health workers.* In some areas, the health workers who go into the community—known variously as psychiatric social workers, social workers, health workers, public health nurses, district nurses, etc.—are able to devote more time to individual patients and families than any of the groups (a) to (c). They should be in a position to allay fears and anxieties about mental disorders.

#### 4.2.2.2 *Community leaders*

If community attitudes are to be changed on a wide scale, it will obviously be necessary to secure the co-operation of persons occupying leading positions, such as politicians, administrators, employers, trade union chiefs, religious leaders, teachers, as well as journalists, and other writers. Such key individuals can be approached on a much more personal basis than the general public. Better collaboration will be achieved if they can become identified with projects which they see as developments of their own interests rather than as something imposed from outside.

If local leaders are invited to participate in working-group committees and to assist in educative propaganda, they can have a powerful influence on public opinion. Membership of mental health advisory committees or administrative management committees enables them to acquire first-hand knowledge of administrative and community problems which were previously foreign to them. In this way, their moral authority is enhanced and their contribution is made more effective.

An important point in respect of community leaders is that not all people follow the same leaders and that the influence exercised by different leaders changes as a society develops. In some areas where, until a short time ago, tribal chiefs may have been the most influential leaders, their place may now be taken by ministers, administrators, creative intellectuals, and others. This shows again that all work towards the changing of community attitudes must be carried out with due awareness of local conditions and local trends.

(a) *Legislators and law enforcers.* The way the law deals with mental patients may be considered to set the norm for the community attitude towards them. Therefore, a considerable influence may be exercised by the formulation and enforcement of laws. Where, for example, there are legal requirements that mentally abnormal persons should be completely segregated from society, attitudes of rejection in the community are probably strengthened.

Where there are laws which impose a strict commitment procedure before anybody can have psychiatric hospital treatment, the community can hardly be expected to regard mental patients in the same light as others.

The law has not only to protect society from the criminal, it has also to concern itself with questions of prevention and treatment. It is here that the law overlaps with medicine and sociology. It seems reasonable to suggest that the various people concerned in the legal procedures need a fairly extensive training not only in matters legal but also in the two other important areas of psychiatry and sociology.

The probation officer plays an important role in combining the punitive and treatment aspects of the law. Properly carried out, probation can serve both to limit crime and to remedy some of the social factors which have contributed to the criminal behaviour. The probation officer also comes into contact with the families of delinquents and can help to interpret the law as something constructive rather than as a hostile authority. In this connexion, the value of the counselling services offered at the magistrates' courts in some countries for people in distress who have not broken the law is frequently overlooked. An example of this type of service is the help given to families in difficulties by magistrates through the use of the probation officer and other welfare workers.

(b) *Leaders in employment.* Mention has already been made of the need to secure the co-operation of employers, but that of trade union leaders is not less necessary. Their influence will help to bring the rank and file of the trade union movement into the process of attitude changing, so that employers, shop stewards and workers will ultimately co-operate in the integration of psychiatric cases in the widest sense of the word into the normal structures of the working community. Understanding attitudes and ready co-operation on the part of both employers and employed would help a great deal in arranging for truly meaningful therapeutic occupation.

(c) *Religious leaders.* A number of theological training courses now include studies in mental health. The possibility of arousing an interest in modern psychiatric practice among local religious healers has already been demonstrated in some agrarian communities. The extension of such action might be considered.

(d) *School-teachers.* Apart from a child's parents, nobody exercises a stronger influence on the social sense of the future citizen than his teacher. If the teacher is aware of his responsibility in this respect and if, in educating the children under his care, he is able to draw on an adequate knowledge of the dynamics of group behaviour, he can do a great deal to improve community attitudes towards persons at present rejected by the community, such as psychiatric patients. Moreover, teachers can play an important role by collaborating with psychiatrists whenever they have to deal with problem children. In some communities, school-teachers are the only really educated persons and enjoy a high prestige which enables them to disseminate information among sections of the population that might otherwise never be reached. Finally, there are, as yet, relatively unexplored possibilities for the introduction of mental health studies into the school curriculum.

Teachers' training courses in many countries include study of the psychology of education. However, it would seem that there is room for more extensive training of teachers in the social aspects of their work. It should be possible for them to have some experience of group work during their training, so that they gain a certain insight into their own personalities and some of their ego defences. Equally important is the awareness of social organization and dynamic factors in a group situation. In addition, it would appear that teachers need a great deal more information about personality development so that they will be in a position to understand some of the anomalies of behaviour which they will find in their classwork.

(e) *Media of mass communication.* Although studies have shown that articles in the press, films, radio programmes, etc., do not always influence

the public in the desired direction, a recent survey of studies on changing attitudes to interethnic and intergroup relations showed that, in general, information put out in this way does have a positive effect. If the press, radio, etc., are to be used as vehicles for educating the public in mental health matters, it will be important to see that writers are provided with unbiased information.

Writers may be assisted in obtaining accurate information on mental health matters partly through press releases and press conferences, where the collaboration of the psychiatrists themselves will, of course, be required, and partly by attempting to associate the press, etc., with various projects, manifestations and undertakings in the field of mental health.

#### 4.2.2.3 *The role of the family*

Reference has already been made to the importance of an understanding attitude within families. Not only the mothers but also the fathers, as well as other members of the family, condition to a large extent the social sense which children acquire. Moreover, nobody is better fitted to exercise a healthy influence both on the patient and on the surrounding community than the members of his immediate or extended family. Parent education is therefore an important means of bringing about favourable changes, and group discussions between the parents of patients are often particularly fruitful.

The tendency in some highly industrialized areas to shift the responsibility for the care of family members to public agencies seems to have been halted, and there is an increasing assumption of responsibility by the family. Interest in the problem of family interaction is growing, as shown by studies such as those on new-town developments, where sociologists are concerned about the disruption of kinship ties resulting from moving families to new settlements. The social anthropologist is also contributing to an awareness of the differences in values between different class systems. There seem to be some grounds for believing that the values subscribed to by under-privileged families are of a very different order from those of middle-class families. The involvement of families in the treatment programme eliminates such obvious difficulties as misunderstanding of the significance of the diagnosis. In the past, a psychiatric diagnosis given in a clinic has frequently implied to the family total disability. If the family members are present and can be given an understanding of the situation in terms that they can grasp, then they will keep the dynamics of the situation in mind, and the role that the various family members have to play in helping the patient will be made clear from the start. Otherwise, the danger that the patient will regress to infantile dependency is very great.

## 5. RECOMMENDATIONS ON RESEARCH

Attitude research is directed at obtaining greater objectivity than would be possible by reliance on individual judgements alone. This is only feasible if proper method is observed; the Committee notes the work recently carried out in this field by the World Federation for Mental Health, a report on which was made available to the Committee.

In this type of research, the precautions taken to make measurements more objective are: (a) a careful pre-testing of interview methods and techniques before applying them on a large scale; (b) the use of very careful sampling procedures, so that the kind of population from which the data are being obtained is known; (c) a statistical analysis of the results, showing whether they can be trusted and whether the differences that have been found can be considered to be real or might have been produced by chance alone.

The use of the interviewing techniques of attitude research raises a number of problems. First, there is the old problem of whether people are telling the truth when they answer questions of the kind used in such research. This is more serious for some types of questions than for others. Thus, if a person is questioned regarding his attitude to a former psychotic or neurotic, his reply may be conditioned by the fact that he thinks he knows the right answer, or the answer he ought to give. In this case, there may be a very real problem of a divergence between his words and his actions. There are, however, techniques that can be applied for reducing the likelihood of this kind of "cheating". Another difficulty arises when people have no opinion, and a third results from the tendency for people to give answers that favour preservation of the *status quo*. It is evident that, in different cultures, this type of attitude research should be applied with suitable modifications. An interview schedule which has been carefully worked out in one country may not prove equally satisfactory somewhere else and will have to be adapted, but enough similarity can usually be found to make comparisons between countries worth while.

With regard to sampling, there are also several problems. Should one always, for example, try to get representative samples, i.e. representative of the total population; or equivalent samples, or effective or relevant samples? There is no easy answer to the question of sampling—different methods will be valuable depending on the circumstances, upon what it is that one wishes to find out.

As to statistical analysis, it is fundamental that, wherever research data are studied on a mass basis, reliable results can only be ensured if adequate attention is given to a careful and methodical weighing of the evidence.

The first priority in attempting to create favourable attitudes is to determine what are the present attitudes in the communities under con-

sideration. Besides indicating the direction in which change is needed, this base-line information serves as a starting point from which to measure the extent to which a programme or project has been successful in bringing about more favourable attitudes.

In the following list, brief indications are given of the types of survey suggested by the Committee for obtaining the necessary base-line information :

1. Community attitudes towards mental disorders : concepts of normality and abnormality in different cultures ; degree of tolerance of abnormal behaviour in different cultures—influence of education, environment (rural, urban) on tolerance ; conceptions of the relative severity of different mental disorders in various cultures.

2. Community attitudes towards psychiatric personnel.

3. Attitudes of psychiatric personnel to one another.

4. Attitudes to types of psychiatric treatment : somatic therapy, psychotherapy, sociotherapy.

5. Attitudes to circumstances of psychiatric treatment : ambulatory, hospital, therapeutic occupation ; attitudes to employment of mental patients under treatment and after discharge from hospital ; the community's expectations as regards the results of various therapeutic procedures.

Further research required for understanding community attitudes towards mental patients would include the following :

1. A study of geographical environment, historical development, cultural patterns, religious beliefs, socio-economic class and education in relation to attitudes.

2. A comparative study of popular terms used for mental illness in different cultures might throw much light on popular attitudes. Such a study might comprise : the collection of terms ; their connotations and possible correlation with scientific nomenclature ; their origins ; their effect on behaviour.

3. A systematic investigation of humour connected with psychiatric topics, as this is often a projection of community attitudes

4. Further research on the correlation between ethnic prejudice and intolerance of the mentally ill, and on the use of the F-scale or similar device for this purpose.

Such studies will need to be carried out as comparisons between different cultures. A regional breakdown will be necessary in many countries, including rural-urban comparisons, but regional comparisons will also be desirable where there is a mixed tribal community. In all these studies, attention should be paid to the rate at which change is occurring. Surveys

made at intervals of six months or a year to see what "normal" changes in attitudes are taking place (unconnected with changes resulting from educational programmes) would be of the utmost importance.

Closely linked with the studies listed above is research on the frequency and incidence of mental disorders. The Committee notes with satisfaction that WHO is elaborating a framework of methodology for carrying out studies on the epidemiology of mental disorders in various countries.

As regards methods of improving community attitudes to the mentally ill and to psychiatric practice, the Committee emphasizes the need for research on the effectiveness of the means used for imparting information on these matters. Investigation is needed into the training of psychiatrists and other medical personnel, as well as potential educators outside the medical profession. Action research, which studies methods of achieving ego-involvement of those concerned with carrying out action, should be valuable for changing community attitudes.

Finally, the Committee wishes to underline the need for interdisciplinary co-operation in such research and the importance of adapting the methods used to the specific social and cultural situation.

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