"Closed Ranks" Twenty Years Later

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In 1951 two researchers, a sociologist and a psychiatrist, tried to change the attitudes toward the mentally ill of the citizens in a small Canadian town (Cumming and Cum-ming, 1957; Cumming, 1954; Cumming and Cumming, 1955). To achieve this goal, they used an intensive educational campaign; they assessed their results by measuring the citizens' attitudes before and after the educational program. According to their own account, they failed to make any dent in the residents of Blackfoot except that, by the end of the six-month test period, their initial friendly reception had been converted to outright hostility. The Blackfooters had closed ranks against them.

What was the prevailing mood in psychiatry at the time the Cummings began their study? There was some interest, following World War II, in the "authoritarian personality" and in the problems of prejudice toward ethnic minorities. The mental hospitals had begun to experiment with patient government, milieu therapy, and day hospital programs. The "schizophrenogenic mother" had made her debut in the literature

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only three years before the Blackfoot study. Tranquilizers were not yet in use, behavior therapy was yet to be, and one looks in vain in the Cummings' bibliography for the names of Maxwell Jones, Goffman, Szasz, Laing, Bateson, or others who have since livened, if not illuminated, the psychiatric scene.

In 1951, insulin shock and electroconvulsive therapy stood high on the list of available treatments, and only two years before, the Nobel Prize had gone to Moniz for his work on prefrontal lobotomy. But Manfred Bleuler (1955), summing up the previous decade's research, felt that the heart had gone out of those searching for a physiological basis for schizophrenia, and that the psychoanalytic viewpoint was beginning to dominate the field. Reading the funeral service over the medical model, he said:

"Looking over these and other works on the pathological physiology of schizophrenics, one is forced to make this negative statement: These works have failed to bring us even one step closer to the possibility of finding, behind the 'psychological' psychosis of schizophrenia, a definable, specific, pathological 'somatic' schizophrenia. We have no

evidence of any disturbance of basal metabolism which would characterize schizophrenia and neatly differentiate it from other psychoses, somatic disorders, or the norm. It is possible that, as a consequence of these negative results, the search for a specific somatic basis for schizophrenia will be given up for a long time to come, if not permanently."

This, then, was the climate of opinion at the time the Cummings began their study.

The exercise of replaying the Cummings' strategy commends itself to us on two grounds. First, the carefully collected before-and-after data was clearly meant to be a resource for future workers in the field. With admirable objectivity, the Cummings have preserved for us something very hard to come by: a complete record of an experiment that failed. Second, the question of community response to psychiatric innovation is even more urgent in the 1970's than it was in the 1950s, and we ought not to throw away any opportunity to learn from the brief past history of such efforts.

There are many approaches which might be used to gain further understanding from the Blackfoot project. We have chosen to apply a method which we have found useful in other instances of controversy or failed communication about mental illness: the construction of models.

Our method is to collect all the different points of view in a controversial situation, and arrange them along a set of dimensions so that they can be systematically compared with each other. The dimensions which we shall use in this paper are: definition or diagnosis, etiology; behavior (how it is to be interpreted); treatment; prognosis; function of the hospital; personnel; rights and duties of patients; rights and duties of families; rights and duties of society; goal of the model. We shall apply this method to the Blackfoot project, and show that the Cummings employed a mixture of six different models (psychoanalytic, medical, social, impaired, science, and conspiratorial), while the Blackfooters used a combined moral, impaired, and "mad" model, as well as a medical model. The only point of substantial agreement between the Cummings and the Blackfooters was the impaired model, one of the least appealing choices, while the only model which could have brought about real agreement and constructive action was the medical model, which was present in only a rudimentary form. Two of the models we have previously described do not appear, for they did not exist in 1951: the family interaction model (Siegler and Osmond, 1966) and the psychedelic model (Siegler et al., 1969).

Because the selection of statements necessary to construct the Cummings' models inevitably reflects our biases, we have given full quotations and page references in some places, rather than paraphrases. All quotations are from the book, *Closed Ranks* (Cumming and Cumming, 1957), rather than from the other two accounts of the study (Cumming, 1954; Cumming and Cumming, 1955).

THE HISTORY OF THE BLACKFOOT PROJECT

The project was undertaken by members of the Psychiatric Services Branch of the Department of Health in Prairie Province, Canada. Its aim was to persuade citizens of a typical small town to increase their understanding of, and so improve their attitudes toward, the mentally ill. The means for achieving this was a carefully prepared, intensive, and sustained educational program. It was hoped that this would result in greater tolerance of the mentally ill, which would help rehabilitation of former mental patients in that community. Attitudes were measured by means of a questionnaire given before the six-month educational program began, and repeated at the end of the period. About 60 percent of the adult population of Blackfoot was reached in this way. In addition, 100 interviews were done before the educational program began and 70 afterwards, using a random sample of adults in the experimental community. A

neighboring community, Deerville, was used as a control: questionnaires were filled out by a random sample of adults, but no educational program was given.

Blackfoot, a town of 1,500 inhabitants, was chosen because it was settled and stable, with a homogeneous population, fairly representative of the southeastern section of the Province, and easily accessible to the home base of the researchers. It was small enough to allow questionnaires to be given to the entire adult population, and large enough to yield meaningful data. Although a conservative town, it had a tradition of learning new ideas from itinerant preachers and teachers.

The educational program consisted of films, radio programs, newspaper articles, and discussion groups. There was no television in Prairie Province at this time. Books on mental health were placed in the town library. The materials used were mainly obtained from the Canadian Mental Health Association and did not differ from those generally used in mental health programs at that time. Rather more than half the adults in Blackfoot had some contact with the educational program and were aware of its content.[1]

The questionnaire contained two scales. One measured "social distance," that is, how close a relationship the respondent is prepared to tolerate with someone who has been mentally ill. The second scale measured "social responsibility," which meant the willingness to assume the responsibility both for the cause and the care of mental illness. By "cause," the Cummings meant that the respondents had provided an environment, however unwittingly, that was causally related to the breakdown of mental patients. The open-ended interview included six brief "cases" describing different kinds of mental illness to which those interviewed were invited to respond.

1. One of the films shown was *"Tight Little Island,"* also called *"Whiskey Galore."* This caused some offense to the teetotal interests. Blackfoot had a reputation as a bootlegging headquarters during Prohibition, and the town was somewhat sensitive on this issue.

The planning committee assumed that, although there might be biological and hereditary bases for mental illness, "there was also a causal connection with long-term disturbances of interpersonal relationships." They believed that if the people of Blackfoot accepted the importance of interpersonal factors, then this would result in their being more tolerant towards the mentally ill and so more inclined to cooperate in their rehabilitation. The authors state: "We reasoned that by teaching that there is little difference between illness and health, we would persuade people to behave toward the ill as they do toward the well."

The committee agreed on three working principles as a basis for the educational program:

(1) Behavior is caused and is therefore understandable and subject to change.

(2) There is a continuum between normality and abnormality.

(3) There is a wider variety of normal behavior than is generally realized.

When the educational program began, the researchers found that the Blackfooters, while not enthusiastic, were willing enough to accept the program and to be helpful. The team began to worry, however, when there was little evidence of any more active interest in the program. Then, in the fourth week of the program, two rumors swept through the town. One was that "the Government" had sent out the research team because "they" were thinking of building a mental hospital in Blackfoot. Second, the survey was said to be a "plot" of the Roman Catholic Church. The team was at a loss to account for these rumors, which were wholly false. Three months after the program began, the researchers began to notice "a pattern of withdrawing behavior." They thought at first that the townspeople were, as they claimed, simply busy with other activities. But this did not seem to be the full explanation. The researchers record: "Toward the end of the program we were beginning to feel that there was

something very wrong." During the second survey, the interviewers grew increasingly tense as they sensed the suspiciousness and hostility of the respondents. They contrasted this with the friendly attitude which had prevailed during the first survey. According to the Cummings:

"The event which best symbolizes our hostile rejection by Blackfoot occurred during the course of the second survey when the Mayor of the town approached one of our interviewers, asking him what he was doing, questioned him in great detail about his credentials and his right to conduct such interviews, and finally said, We have had too much of this sort of thing; we are not interested in it in this town any more. The sooner you leave, the better.' The ranks had closed against us. Blackfoot had responded as if to a threat to its integrity as a functioning community/'

At the conclusion of the educational program, the Cummings found that the average score of the two scales had not changed, which they took to mean that the average person in Blackfoot was neither willing to get any closer to a mentally ill person nor willing to take more responsibility for the problem of mental illness than at the beginning of the program.

At this point, it is important to realize that the Cummings did no reconnaissance at all in Blackfoot; they assumed that they knew what the Blackfoot people felt about mental illness. Furthermore, neither the first questionnaire, the second questionnaire, nor the interviews were analyzed until *after* the educational program was over. Thus, the Cummings were cut off from feedback of any kind from their respondents. The baseline from which the Blackfooters were to be moved was not considered when the educational program was being developed.

How did the Cummings account for their failure to change the Blackfooters' attitudes? On examining their data, they discovered that, contrary to their original assumption, the Blackfooters perceived a much broader range of behavior as normal than the mental health workers who were trying to increase their tolerance of abnormality. Their second assumption, that behavior is caused, and therefore understandable, was true also for the Blackfooters who, however, saw very different causes from the Cummings. The Cummings had erred in assuming that lay people wait for professionals to tell them what to think, whereas it became clear in retrospect that most people believe that they understand human nature. With their third assumption, that there is a continuity between normality and abnormality, the Black-footers did not agree. They saw a fairly sharp cutoff between the two. The Cummings came to feel that the pattern of rejection, isolation, and denial that prevailed among the Black-footers about the mentally ill was functional for them, both in promoting social solidarity among the sane and in relieving feelings of guilt about their treatment of the mentally ill. Thus, it is not surprising that the Blackfooters became increasingly angry at them for disrupting this pattern.

In retrospect, the Cummings believe that they would have done better if they had been more alert to rising anxiety; if they had used an opportunity to become involved with plans for a projected community center; and if they had not used a psychiatrist at all. They also believed that the same materials introduced over a longer period of time might have been less anxiety-provoking.

MODELS USED BY THE CUMMINGS

The psychoanalytic model

A. The model described 1. Definition "There is a continuum between normality and abnormality." (p. 20)

"We reasoned that by teaching that there is little difference between illness and health, we would persuade people to behave toward the ill as they do toward the well." (p. 21)

2. Etiology

"While the Committee members were aware of the biological and hereditary bases of mental illness, they believed there was also a causal connection with long-term disturbances of interpersonal relationships." (p. 19)

The Cummings' belief in the psychogenic etiology of mental illness can also be inferred from the child-rearing emphasis of the educational program:

"Later in the year, a weekly radio program sponsored by the P.T.A. and financed and administered by the project was presented over a twelve-week period. Known as 'Junior Jury,' this program consisted in panel discussions of problems of childhood, discussed first by a group of children, then by a group of parents, and finally by a psychiatrist who summarized the discussion. Most problems were submitted by the school children themselves and presumably arose out of their life situations. Typical questions dealt with sibling rivalry, with authority relationships with parents, and with the degree of autonomy a child should have regarding money and property." [p. 27)

3. Behavior

(From a case history of Mary White, a phobic girl with compulsive features): "... she just can't leave the house without going back to see whether she left the gas stove lit or not. And one more thing about her: she's afraid to ride up and down in elevators: she just won't go any place where she'd have to ride in an elevator to get there." The Cummings' comment: "There was no respondent who expressed any suspicion that this might be symbolic behavior or that fear of elevators might protect Mary White from other more disturbing unconscious fears." (pp. 97-98)

4. Treatment

The Cummings do not discuss treatment for these disorders, which they wished the Blackfooters to see as psychogenic. However, the usual treatment offered in this model is psychoanalysis or psychotherapy of some kind.

5. Prognosis

The Cummings believe that using this model would "make rehabilitation easier." (p. 19)

6. Function of the hospital

"Hospitalization removes the patient from the sources of stress which may have precipitated his disease or aggravated his non-conforming behavior." (p. 132)

7. Personnel

The Cummings do not discuss who ought to treat the mentally ill using this model.

8. Rights and duties of patients

We can infer that patients in this model have the right to have their behavior viewed symbol ically, rather than morally or medically (p. 105). Also, they have the right to be treated the same as if they were well (p. 21). The Cummings do not discuss what their duties might be.

9. Rights and duties of families

From the emphasis on child-rearing practices and child development, it can be inferred that the family has the duty to bring up the child in such a way that he does not become mentally ill. To put it the other way around, if a person becomes mentally ill, one might conclude that this was due to shortcomings in his upbringing. The rights of the family are not discussed.

10. Rights and duties of society

The Cummings seem to feel that society has the duty to be more tolerant of the mentally ill since they are not fundamentally different from the rest of us; they are simply at the other end of the normality-abnormality continuum. The rights of the community, or society, are not discussed.

11. Coal of the model

The goal of this model is to abolish mental illness by teaching people to see the mentally ill as people just like ourselves, with, perhaps, more severe forms of the emotional problems to which we are all liable.

B. The model discussed

The first thing that strikes us about the Cummings' version of the psychoanalytic model is its incompleteness. As we have stated before (Siegler et. al., 1968), a model must provide an answer to every question and a course of action for every situation which might arise in connection with mental illness. The directions provided by the Cummings' model are sketchy indeed. We do not learn, for example, how one is to tell minor emotional disturbances from major ones, nor if the proposed course of action varies according to the severity of the disturbance. If these emotional disturbances are to be differentiated from organic illnesses, it is not suggested how this might be done or who would do it. They do not offer any evidence that the solution of ordinary daily problems, such as those discussed on “Junior Jury," would decrease the number of patients ill enough to be hospitalized. It is not clear what advantage would accrue in interpreting behavior as symbolic rather than in some other way. No treatment is discussed for any patients along the proposed continuum, nor is any prognosis offered for people with different degrees of disturbance. We do not learn what is to be done with those currently in the hospital. We are not told what qualifications people ought to have in order to work with the mentally ill.

It is not clear how patients ought to behave, nor what their families have the right to expect. It is not clear whether society is mistaken in imagining that some mentally ill persons present a danger to themselves or others; indeed, it is not clear whether society has any rights at all under this model.

In sum, this model, as deduced from the Cummings' study, does not give clear instructions for patients, their families, those treating the mentally ill, or for members of the community in which they all live. However appallingly it might have been presented, it does not tell anyone what to do when actually confronted with mental illness.

The second thing to be noted about the Cummings' psychoanalytic model is that it is in the dimension of "definition" that the researchers ran afoul of the Blackfooters. It was the concept of a continuum running from mild emotional disturbance through to grievous psychiatric illness that the Black-footers could not accept. The Cummings believed that the way to get the Blackfooters to be more tolerant of the mentally ill was by enlarging their understanding of the normal mechanisms of behavior in ordinary life situations. As they put it: "On the basis of the concept of the equilibrating function of prejudice for some people, we decided not to make a direct attack, at least at first, upon the attitudes of the members of our community toward the mentally ill but to approach by way of the more general subject of human behavior." (p. 20) But, as the Cummings noted later, the Blackfooters were already sold on the value of understanding human behavior: "Modern teaching about child development has really 'taken' and become a significant part of people's thinking. The brisk sale of books on this subject and its popularity for discussion at parents' groups further indicates its acceptability." (p. 157)

Therefore, the main thrust of the educational program was to teach the Black-footers something that they already knew. But it does not follow that, if one accepts the teachings of modern psychology about normal behavior, one will find that this erases the differences between normal people and the mentally ill. What makes an encounter with a psychotic person such an eerie experience is the disconcerting discovery that one's usual understanding of human nature breaks down in the face of inexplicable behavior: this is the very definition of psychosis. If there is any correlation between a psychodynamic view of human nature and tolerance of the mentally ill, it is an inverse one: people who are alert to psychological subtleties and have high standards for in-terpersonal relationships are sure to notice that the mentally ill are greatly handicapped where social and emotional flexibility is required. Thus it is not surprising to learn that the Blackfooters proved to be more tolerant

of the mentally ill than the more sophisticated Cummings and their colleagues.

The science model

A. The model described

The Cummings used this model on one occasion only when, for unknown reasons, they attempted to establish their authority in relation to the agricultural scientists in Black-foot:

"A public debate on the subject of whether or not social science is really a science was arranged with the agricultural station group. Although this debate was rather lively in a somewhat incoherent way, it seemed amiable enough: therefore we were surprised to learn from acquaintances that it had raised considerable antagonism among the agricultural scientists present. In content, the discussion seemed innocuous: the speakers for the social science side emphasized the contributions of R. A. Fisher to the art of experimental design, and the agriculturalists insisted that 'man is too complicated to be studied scientifically.' Which aspects of the debate annoyed the agriculturalists most is still in doubt, though we will suggest in a later section that it was not the content of the debate but the fact of the educational team, by their actions, implicitly calling themselves scientists which was so vexatious." [p. 31)

B. The model discussed

We do not know why the Cummings felt that a public debate with the agricultural scientists would improve their chances of creating greater tolerance for the mentally ill in Blackfoot. They themselves offer no explanation for this eccentric action. The best guess which we can offer is that, having largely abandoned medicine as a source of authority, they still wished to establish that they were authorities of some kind and tried to present themselves as scientific experts. Psychoanalysis seems to have been a poor source of authority in Blackfoot; such authority as it has derives from medicine.

They did not argue that the psychoanalytic concepts underlying their program were scientific, which might have been a more logical, though perhaps more difficult, thing to do; instead, they tried to show that their method of designing the study was scientific. It is evident that their arguments were not directed at the people of Blackfoot to impress them with their expertise regarding the cause and cure of mental illness. Rather, they went over their heads, so to speak, to address their agricultural scientist colleagues living in Blackfoot on the merits of their research abilities.

The medical model

The Cummings did not consciously or deliberately use this model, but it is implied in the setting of the study, the Psychiatric Branch of the Department of Health and Prairie Province, and in the fact that one of the Cummings was a psychiatrist — that is to say, a medical doctor in the process of being trained in psychiatric medicine. The study could not have been done without the blessing and active support of the Health Department.

Had the Cummings wished to use the medical model, an obvious step would have been to enlist the cooperation of the doctors practicing in Blackfoot. But, in fact, they moved in exactly the opposite direction. They concluded that it was a mistake to have had any medical person on their team at all:

"It is probable that a psychiatrist — as in our case — should not be placed in a position where he is the chief organizer and one of the major contributors to a mental health program. Such activity, to most people, is simply not appropriate to the role of a specialist physician, and this probably acted against acceptance of our program in Blackfoot." (pp. 155-156)

Yet other medically sponsored programs were wholly acceptable to the people of Blackfoot. The Cummings note that

"*... during the course of our experiment, an outside effort to incorporate the town of Blackfoot into a larger public health*

unit was made. The proponents of the scheme, Provincial civil servants, entered the community with considerably more directness than we did: they distributed literature, hired a hall, and when people came, told them about the plan. Blackfoot people argued with the proponents of the scheme, but they listened, and when the matter came to a vote, the town, which seemed completely opposed to a change, voted for the formation of such a health unit.' (p. 26)

The Cummings use this example to show that the Blackfooters were not suspicious of outsiders. A more useful inference to be drawn from this example is that programs explicitly using a medical model (in this case, a public health medical model) are readily accepted in a town such as Blackfoot. They are not perceived as threatening, they do not have to be approached indirectly, and they do not generate hostility.

The impaired model

The Cummings give us one example of the use of the impaired model. This was the point in the program at which they seem to have achieved the greatest consensus with the Blackfooters:

"Probably the most successful event of the program was the engagement of several members of the Blackfoot branch of the Canadian Legion in a project which took them seventy-five miles to visit a veterans' group in a ward of a large mental hospital. These men were given a one-hour introduction to the problem of the chronic ward by the superintendent, and following this, they visited the patients. The Legion members voted at their next meeting to adopt this ward as a continuing project, sending cigarettes, candies and other comforts. It is of particular interest that this Legion group decided not to limit its interest to the veterans when sending comforts to the ward but to include the whole ward in its project. Apparently the governing Legion principle of service to veterans was temporarily replaced by a broader interest in all the patients in the hospital." (pp. 31-32)

It is important to realize the implications of sending candy and cigarettes to hospitalized patients. Normally, people prefer to supply these things for themselves, or, if they are too ill to do so, they enjoy receiving them from family or friends — from someone who knows them and cares for them. The implication of a group of Legionnaires sending candy and cigarettes to a whole ward is that the patients lead a captive and impoverished existence, perhaps permanent, in which they can be expected to be grateful for anything that anyone chooses to do for them. To a patient in a general hospital, one sends fresh flowers, which people do not ordinarily buy for themselves, the implication being that one is getting a special treat because one is sick.

If this project does not fit the medical model, it makes even less sense in terms of the psychoanalytic model. If mental patients are just like everyone else, why then are they living in an institutional building 75 miles from Blackfoot, depending upon total strangers to supply ordinary daily needs such as cigarettes? Yet the Cummings found nothing incongruous about a project so far removed from those stated principles which they were trying to teach the Blackfooters.

The social model

One of the two scales used by the Cummings in their questionnaire was the "social responsibility" scale. The Cummings wished to measure whether the people of the community felt that they were at all responsible, as citizens, for the occurrence of mental illness. They also wished to know whether those who felt social responsibility for mental illness also felt responsible for caring for the mentally ill. There was indeed such **a** relationship:

"It is perhaps not surprising that those who see the causes of mental illness residing in the economic or social system also consider themselves responsible for it, while

those who see the cause as biological disclaim responsibility. Especially is this likely to be true in a Province with a long history of radicalism of the sort which heavily emphasizes social welfare. Tentatively, we might predict that people will feel more responsibility for a problem if they see the causes — or cures — of that problem amenable to manipulation at the large-group level, that is, through legislation, reform, and so on, than if the causes are essentially inside people." (p. 69)

In the psychoanalytic model, at least as it is usually understood, people **are** encouraged to see the source of their illness as lying within themselves. In this dimension, etiology, the psychoanalytic model and the social model are in contradiction. Yet the Cummings seem to subscribe to both. A possible explanation for this may be the vagueness of the social duties of citizens as described by the psychoanalytic model. They are to be "more tolerant." The Cummings wish to see a more active role for citizens in respect to mental illness, and so they are probing to see if the socially-minded Blackfooters accept the causes of mental illness as lying within the community.

The Cummings found that those who believe the causes of mental illness to be biological are less willing to feel responsible for doing anything about it. This is strange, for in two models, the medical and the impaired; people have demonstrated the willingness to take social action on behalf of the sufferers, although they clearly do not feel responsible for having caused the condition. In the impaired model, the blind, deaf, and crippled are all recipients of social concern and aid. Using the medical model, there are many examples of organizations founded by lay citizens to further research and treatment for a particular disease: the National Foundation, and so forth. One does not need to make members of a community feel that they have caused an illness in order to get them to take responsibility for doing something about it. Indeed, the typical stance taken by these organizations is that the causes of the disease in question are unknown, and cannot be determined except by long-term, expensive, and effortful research. People are made to feel that the disease is an external enemy to be fought, rather than an interpersonal problem or the manifestation of a "sick" society.

The conspiratorial model

In 1951, the conspiratorial model, as we have described it elsewhere (Siegler and Osmond, 1966; Siegler et al., 1969; Siegler and Osmond, in press) was not yet in full bloom; the writings of Goffman, Szasz, Laing, and Scheff had still to appear. In **Closed Ranks,** there is just the faintest suggestion of it, but it is worth looking at this one harbinger of things to come. The Cummings were frequently asked why they wanted to know what the Blackfooters thought about mental illness: why not ask the experts, they wanted to know. To which the Cummings would reply, cryptically but significantly: "Who sends people to mental hospitals?" (p. 22)

The Cummings tried to convey the message that some of the patients in the hospital were no more ill than those who remained harmlessly at home. There we see the germ of the idea that mental illness is just a label which some people are unfortunate enough to get pinned on them, while others in no way different escape this fate. This model conflicts with the psychoanalytic model in the dimension of "definition." In the psychoanalytic model, symptoms which would normally go unnoticed are seen as evidence of emotional disturbance, while, in the conspiratorial model, one is discouraged from labelling anyone as mentally ill since this is seen as a prejudicial act. The conspiratorial model also conflicts with the medical model in the same dimension for, in medicine, the sooner one notices the early symptoms of a disease, the better the chances of treating it. Consequently, failure to notice symptoms as early as possible is certainly a mistake, and may even be considered negligence.

MODELS USED BY THE BLACKFOOTERS

The moral model

A. The model described

1. Definition

Most people are moral, i.e., they behave according to the mores of customs of their society. There are a few people whose behavior is so non-normative and unpredictable that they must be put into a mental hospital. As the Cummings put it: "Mental illness, it seems, is a condition which afflicts people who must go to a mental institution, but up until they go, almost anything they do is fairly normal." (p. 102)

2. Etiology

Sometimes people who behave badly have been raised in a way that is too lenient or too harsh. Often, some specific past experience, such as betrayal by another person, causes bad behavior. Some people are just born mean, weak-willed, or lacking in character.

3. Behavior

Behavior should be taken at face value. For example, the girl who always had to go back to see if the gas stove was lit or not had probably caused a fire at one time and had learned to be more careful, (pp. 97-98) The Cummings comment: "... we find that Black-foot residents seem to perceive a much broader range (of normal behavior) than do the mental health workers who were trying to teach them to be more tolerant of abnormality!" (p. 92)

4. Treatment

When a person behaves badly, his friends should tell him to "snap out of it." If a child misbehaves, he probably needs sympathetic guidance and understanding; it is his parents who are at fault.

5. Prognosis

Most people respond to moral sanctions and helpful advice from others. But those few people who persist in immoral and unpredictable behavior must go to a mental hospital and then the prognosis is hopeless.

6. Function of the hospital

The mental hospital is the best place for someone who no longer responds to the usual moral sanctions: they have the finest treatment there.

7. Personnel

All moral, responsible adults can help others to behave acceptably by telling them when they are getting out of line. However, once someone has shown that he does not respond to ordinary sanctions, then he should be sent to a doctor, and then, if the doctor can't set him straight, to a mental hospital, where they have a fine staff of doctors and nurses to help people.

8. Rights and duties of patients

The mental patient has the right to be sent to a mental hospital because the finest treatment is available there. He does not have the right to live in the community any more, because he has violated its norms. He does not have the right to return to the community, because he is no longer predictable.

9. Rights and duties of families

Families have the duty to try to get their members to behave normally, by treating them neither too harshly nor too leniently, and teaching them right from wrong. However, if this teaching fails, the family has the right to hospitalize a member who does not respond to these sanctions, because it is too worrisome and disruptive to have him living among them. The family also has the duty to hospitalize a mentally ill person, since that is the best place for him.

10. Rights and duties of society

Society has the right to extrude those members who are non-normative and unpredictable, who might be dangerous, and who do not respond to the usual moral sanctions. Society has the duty to provide a place, preferably distant from the community, where the unfortunate mentally ill person can be cared for and given the best available treatment. Society has the right to regard mental patients as socially dead, because they are too unpredictable to rejoin the community.

11. Goal of the model

The goal of this model is to ensure the integrity of the community by extruding those few people who do not respond to the usual moral sanctions, and to provide a place for those people where they are cared for and given such treatment as is available for them.

B. The model discussed

The model of mental illness which the Blackfooters used was primarily a moral model, in that it focused on the social behavior of members of the community. Most people behave in a way that makes sense in terms of the way they were raised, the standards of the community, and the particular experiences which they have had. Only a small minority of people cannot be fitted somehow into this normal social existence. Those people who simply cannot be made to fit, or whose behavior cannot be rationalized as normal, must be extruded from the community so that it can continue to function. This minority are crazy, mad, insane. Once they have been extruded, it generates too much anxiety to take them back again, because they have already demonstrated their unpredictability and their lack of response to the usual sanctions.

Madness, then, is that residuum of behavior which is left when all known explanations have been exhausted. When we use the Word metaphorically, as when we say that some political leader's actions are "mad," we mean that we do not know and cannot even imagine what explanation might be found for them. The Blackfooters managed to keep the number of mad people as low as possible by giving everyone who behaved strangely the benefit of every doubt. This was the best they could do in the absence of information which would describe the inner experience of mad people and so make their behavior understandable and even predictable, or more nearly so.

Once mad people are inside mental hospitals, however, an interesting model-switch occurs. They are no longer seen as mad, unpredictable, and potentially dangerous. Within the hospital, there is an atmosphere of sluggishness and apathy, rather than the atmosphere of anxiety and acute danger which often exists up to the point where someone is taken to the hospital. Within the confines of the hospital, the mad person's behavior usually becomes predictable, and so much less dangerous. He is now seen as impaired, that is, as permanently occupying a somewhat subhuman role as a damaged or crippled person. The transition from madman in the community to impaired person in the hospital is rather like the transition of a wild animal in the jungle to a sleepy lion in his cage. It should not surprise us, then, that mental hospitals used to charge admission to see the patients, just as if the hospital were a zoo. But although the impaired role is not an attractive one, it is at least an improvement over the mad role, in that the mentally ill person is cared for and can hope to survive until some other role is made possible for him. It is better than being put aboard a ship of fools or simply being driven out from the community to freeze or starve.

As we have noted above, both the Cummings and the Blackfooters were able to agree on the impaired model in the instance of the Legionnaires "adopting" a ward of patients at a hospital 75 miles from Black-foot. The impaired model can be made very comfortable and rich impaired people like the residents of the Magic Mountain (Mann, 1927) live very much better than poor impaired people. To have visitors who bring candy, cigarettes, and their company is surely better than to be impaired without these comforts. The Cummings did, therefore, succeed in improving the lives of some mental patients occupying the impaired role, and both they and the Legionnaires evidently experienced that sense of well-being which accompanies an act of betterment.

If the impaired model were fully adopted by the Blackfooters, they could greatly enhance the lives of hospitalized mental

patients by introducing all sorts of improvements and luxuries. After all, people who are cut off from any hope of rejoining the community and leading normal lives certainly deserve our best efforts at compensating them for their ill-luck. But unfortunately, it does not seem to work that way. For unknown reasons, the status of impaired people always seems to be lower than that of normal people or ill people, and so the efforts to make their lives more bearable usually fall far short of this humane and equitable goal.

The medical model

As we have indicated, the model used most by the Blackfooters was a moral model, with a mad-impaired annex for those who had to be extruded from the community. However, the medical model was not entirely absent. When someone is behaving in a non-normative and unpredictable way, and if the efforts of family and friends to set him to rights do not succeed, the next step is to send him to a doctor. If the doctor is unable to do anything, the afflicted person is then sent to a mental hospital, which resembles other hospitals, at least insofar as it has a medical staff and offers some medical treatments. He is not simply extruded, or sent to a madhouse, which would be the logical step using the Blackfooters' model consistently. That is to say, the medical model has successfully encroached upon the mad model to the extent that there is at least a token effort to regard the madman as a medical patient with the appropriate rights and duties of the sick role.

THE CUMMINGS VERSUS THE BLACKFOOTERS

The Cummings failed to move the Black-footers from what was mostly a moral model to what was mostly a psychoanalytic model. We can see several possible reasons for this. First, the psychoanalytic model to which the Cummings subscribed was so vague in its formulation that the Blackfooters were hard put to see how this new view would help them cope with the realities of mental illness. The fact that this model, with all of its internal shortcomings, was mixed in with bits and pieces of five other models muddled the Blackfooters and reduced their confidence in the Cummings as a useful source of information.

Then, at the outset of their study, the Cummings did not know what model the Blackfooters already held; they guessed, but were mistaken. As nearly as we can make out, the Cummings thought that the Blackfooters believed that some sizable proportion of the population was mentally ill, and that what they meant by mental illness was madness.[1] In fact, unlike their mentors, the Cummings, the Blackfooters saw most people as normal and reserved the category of madness for a tiny fraction of their community who could not possibly be subsumed under the moral model. Even then, the mad model was applied only until such a person was safely put away in a mental institution; from that point on, the mental patient was seen primarily as impaired — harmless, but socially dead. Since the Cummings also saw hospitalized patients as impaired, rather than ill, mad, or emotionally disturbed, their only positive contribution was to make a slight improvement in the version of the impaired model which the Blackfooters already held.

Given that the Blackfooters held a moral model, with a mad-impaired annex for a tiny minority, to what model could they have been moved by a six-month educational program? Let us consider the possibility that the Blackfooters could have been moved to a

2. It should be noted that while the Cummings suggested that there might be an indefinitely large number of mentally ill people, it is quite easy to calculate the number actually in Blackfoot The gloomiest calculations might suggest that about 10 percent of the population would be ill at the same time. However, thanks to the Blackfooters' surprising tolerance, it seems probable that no more than three or four of them were in the Provincial hospital, and perhaps one or two in the local psychiatric ward, at the time of this study. In view of the actual conditions of overcrowding and under-financing in the hospital at that time, it hardly behooved the educators to encourage the Blackfooters to become less tolerant than they were. There is no evidence that the Cummings concerned themselves with these crude but relevant logistics, which require a medical bias to recognize their importance.

medical model in this period of time, for both the Cummings and the Blackfooters already held a medical model of sorts, as is reflected in the Cummings' medical sponsorship, the fact that one of them was a physician, and the fact that both parties used the terms "doctor," "hospital," "ward," and so forth, without seeing any problem in this terminology. Indeed, they did not feel the need to put these otherwise inappropriate words in quotation marks. Neither party raised the possibility that the medical model be totally abolished, nor, on the other hand, did either suggest that the medical model be more fully implemented. The medical model has been made invisible by familiarity, and no one recognized how many benefits might accrue if it were fully employed for mental illness.

Had the Cummings wished to convert the Blackfooters from a moral-mad-impaired model to a medical model, how ought they have set about it? First, they should have found out which diseases the Blackfooters had had to deal with most frequently. They might have asked local doctors to help them with this. Probably schizophrenia, depressive illnesses, alcoholism, and senile psychosis would have been on the list. Then, they should have gathered current research information so that they could tell the Black-footers what progress had been made recently in understanding and controlling these diseases. They should have told them what research was then going on in the laboratories of Prairie Province and who was doing it; this might have been encouraging news. They might have filled them in a little on the history of other psychiatric illnesses, such as pellagra psychosis and general paresis of the insane, which were also once thought to be very mysterious but which are now much better understood. They should have emphasized that psychiatric illness can strike any family, just as other diseases do, which is not the same thing as saying that everyone is somewhat mentally ill.

They should then have alerted people to the early symptoms of some of these diseases, pointing out the benefits of early diagnosis and treatment. They should have discouraged the Blackfooters from excessive tolerance, which had led to mental patients being kept in the community untreated for much too long. They might have pointed out that with other illnesses, such as tuberculosis, cancer, and leprosy, the stigma of the diseases has gradually been removed as people have been encouraged to call the disease by its name and learn as much about it as they can. In the case of leprosy, for example, the name of the illness was changed to "Hansen's Disease," but has recently been changed back again to leprosy, so great is the confidence that the stigma has been removed, at last, from the once-terrifying name (Bloombaum and Cugelyk, 1970).

The way to get people to accept the mentally ill is to see them as medically sick, exactly the same way that cancer patients or heart patients are sick, not "sick, sick, sick." If you have the sick role, you do not need the mad role. If you use the sick role and the medical model, you can dare to identify a young person as schizophrenic, for you are not "labelling" him, calling him mad, or imputing that his personality is twisted. You are telling him that he has an identifiable illness, for which new treatments are being developed all the time and which he has a good chance to bring under control, the more so if he treats it while he is young. You are telling him that he need not estrange himself from his family, for they have not caused his illness. You are telling him that, if he demands and learns to follow the rules of the sick role, he can be treated with the dignity and respect which is accorded to any person contending with a grave illness. You are telling him that the great compassion of well people for sick people will be his, and the great energy which medical science exerts against disease will be employed on his behalf. You are telling him that in the centuries-old struggle against mad ness, there is now real hope, for the first time, of a victory over our ancient adversary.

DISCUSSION

In trying to discover what went wrong with their educational program, the Cummings made a number of suggestions as to how it might have been improved. The essence of these suggestions is that the Cummings believed that they should have acted more slowly and trod more delicately in moving the Blackfooters from their model to the Cummings' own. One possibility that the Cummings did not consider was that their model was useless, and that the Blackfooters, realizing this, rejected it on very good grounds. It is never easy to consider the possibility that others have not responded to our teachings because those teachings, however carefully planned and well-intended, are mistaken. It is more comforting to believe that if only we had been a little cleverer, if only we had put it a little differently, the others would have been won over. To be sure, the Blackfooters' model was not ideal, and they knew it; hence their anger at having it exposed to the light. But their model, while unattractive, worked, whereas the Cummings' model, which they felt was far more humane and up-to-date, proved to be unworkable and probably harmful. Luckily, one does not have to restrict oneself to these two choices — one can and must look for a model which is humane, appealing, and functional. In our opinion, the medical model used with skill, imagination, sympathy, and elan fills the bill in psychiatric illness, just as it has done in the past and is doing today in so many other illnesses.

As regards mental illness, communities have no choice; they must cope with it, and have always done so. Thus it is not surprising to find that Blackfoot, like every other community, has a model which has stood the test of time. We may be assured, however, that if mental health workers truly have a model which is superior, and not just novel, this wonderful news will travel. When this happens, they will be invited into the community, as experts, to teach what they know, and they will find that the ranks have opened to welcome them.

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