Stigma and Mental Illness: Theory Versus Reality

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The stigma of mental illness—the negative attitudes toward and rejection of the mentally ill—is a topic that has received increasing attention in recent years. The President's Commission on Mental Health (1978) recommended that a task force be established to help reduce stigma, to improve public understanding of mental illness, to assist former patients in the community, and to encourage the mass media to present more accurate descriptions of the mentally ill. The National Institute of Mental Health sponsored a research workshop on attitudes toward the mentally ill in an effort to identify the questions most central to eliminating discrimination and promoting a better life for former patients in the community (Rabkin, Gelb and Lazar, 1980). The present conference for Alabama mental health professionals—on the barriers imposed by stigma, methods for resolving these barriers, and growth toward community acceptance of the deinstitutionalized person—is the latest, but surely not the last, effort of this kind.

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Personal accounts of mental illness and hospitalization by former patients are not all in agreement regarding the real or perceived effects of stigma. Houghton (1980), for example, claims that the stigma of mental illness is devastating. A graduate student in psychology at the time of her illness. Houghton describes the way she was discriminated against by her professors, who tried to prevent her from completing her degree, and the negative reactions toward her by community leaders. Similarly. Smith (1972), in his day-to-day account of life as a patient in a state hospital, talks about the de-humanization and rejection experienced. On the other hand, a sociologist-patient believes the mental hospital had facilitated rather than retarded his recovery (Killian and Bloomberg, 1975). He confesses that before being committed he had feared institutionalization, the label of mental illness, and the disdain of friends and relatives, but that after discharge he felt the experience had been a pleasant one and sensed no stigma. Many of the protocols quoted by Rosenblatt and Mayer (1974) indicate that patients do not feel shame or embarrassment when returning to the hospital. Such

patient autobiographies, as Sommer and Osmond (1960, 1961) noted more than two decades ago. reveal the complexity of the dynamics involved in mental illness and hospitalization.

The present address is an evaluation of the role stigma plays in the lives of patients and former patients. First, theoretical works on stigma and mental illness, together with the authors' major theses or arguments, are presented. Second, empirical studies of stigma and mental illness are reviewed and the key findings delineated. With these two bodies of literature at hand, the data are then evaluated to determine if the theory of stigma with respect to mental illness coincides with the reality of patients' hospital and posthospital experiences.

THEORETICAL WORKS

The term stigma comes from the Greek and means a mark or brand on the body, especially one that signifies shame and brings discredit to the individual. The earliest reference to the idea of stigma appears to be in the Bible. In Genesis (4:8-16) we learn that Cain slew his brother Abel, and that God punished Cain by banishing him from Eden and making him a fugitive and a wanderer. God set a "sign" on Cain's forehead, so that no one would smite him (thereby lifting the punishment) and that everyone would know the terrible deed he was guilty of.

The most important theoretical work on stigma is undoubtedly that by Goffman (1963). He posits that the term stigma is today still widely used in the original Greek sense, but is applied more to the disgrace itself than to the bodily evidence of it. Goffman differentiates three types of stigma: abominations of the body (physical deformities or handicaps), blemishes of individual character (mental disorder, alcoholism, drug addiction, homosexuality, criminality), and social impairments (of race, nationality, religion, caste, or class). Stigma is universal, as all societies establish the means of categorizing persons and determine which human attributes are praiseworthy and which are discrediting. Goffman emphasizes strongly that stigma is a characteristic that is imputed by society to a given attribute and is not inherent in the attribute itself. Stigmatization thus varies according to time, place, and circumstance. The character bestowed on an individual becomes, in effect, a social identity. Stigma greatly influences a person's self-conceptions and interactions with others.

According to Goffman's theory, the stigmatized are primarily concerned with the management of their spoiled identity. Persons with a particular stigma have similar learning experiences regarding their plight and similar changes in self-conceptions—a similar "moral career" that is both cause and effect of personal adjustments. In this socialization process the stigmatized learn and incorporate the perspective of the normal person, the identity beliefs of the wider society, as well as learn what it is like to possess a particular stigma. Those with an inborn stigma, for instance, adjust early in life to their disadvantageous position, i.e. learn to manage the stigma while learning normal social roles. Those acquiring a stigma late in life have a serious adjustment to make, and often deal better with and are accepted more by post-stigma rather than pre-stigma acquaintances. The management of stigma—how to conceal it. disavow it. or claim a more favorable social identity—depends largely on such factors as the visibility of the stigma and the stigmatized's personality, techniques of information control, and group alignments.

The link between stigma and mental illness is more direct in another work by Goffman (1961) Here, based on participant observations of a large state mental hospital. Goffman maintains that institutionalized patients feel a strong sense of stigma. They have identity problems, experience greater social distance between them and others, and suffer anxiety over loss of self-esteem. The hospital's bureaucratic and authoritarian structure leads to a "mortification of self" in patients—restrictions on liberties, depersonalization of relationships, dispossession from normal social roles, abuse by staff, profanations by other patients. Patients have to adopt a "psychiatric line" in order to get released, i.e. they have to sacrifice their own values and identities in order to be judged as sane and get out of the hospital. In Goffman's view, the stigma of mental

hospitalization is great; persons acting abnormally but who are not hospitalized are not stigmatized by society.

Another theoretical contribution to the literature on stigma and mental illness was made by Cumming and Cumming (1965). They see stigma as a "loss", a stain on one's good name, a loss of reputation, a reduced social competence. The Cummings argue that stigma acquires its meaning through the emotion it generates within the person bearing it and the feeling and behavior toward him/her of those affirming it. Thus, patients may feel shame or inferiority because they have been in a mental hospital, and this may lead them to behave in a manner that induces others to respond in ways consistent with this sense of stigma. Because it is the loss of a behavioral attribute, the stigma of mental hospitalization may be reversed or at least attenuated. Patients and their families, for example, may define the illness as a "nervous breakdown" and the hospitalization as a mistake. Stigma, according to the Cummings, is likely to be felt when patients or their families cannot exempt the patient from the loss of a valued attribute.

The labeling theory or "societal reaction" perspective to mental illness also has relevance for the conceptualization of stigma. Scheff (1966) presents a sociological model for mental illness, one that is the polar opposite to the medical or psychiatric model. Mental illness, rather than being viewed as an abnormal condition within the individual, is seen as a label attached to persons who engage in certain types of deviant activities. The symptoms and abnormal behavior characteristic of the mentally ill are taken as violations of social norms, products of situations, rather than the result of some personal predisposition or specific psychopathology. Persons labeled mentally ill structure their deviance to conform to the behavioral expectations and cultural stereotypes of the mentally ill. Chronic mental illness is thus a social role, and the societal reaction is the most important determinant of entry into that role. Once a person has been hospitalized, he or she has been publicly labeled "crazy" and forced to become a member of a deviant social group. Sociologists perceive
hospitalization negatively, in terms of stigma, because it tends to reinforce the very behavior it is supposed to correct. It is then difficult for the deviant to return to his/her former level of functioning as the status of patient causes unfavorable evaluations by self and others. Labeling theory assumes that when ex-patients are rehospitalized it is due to the effects of social rejection, conditions having nothing to do with the person's mental illness. Not all sociologists agree with the societal reaction perspective on mental illness, and there has been a great deal of controversy over it. The chief iconoclast of the labeling perspective has been Gove (1970, 1975).

Goffman's notion of stigma and sociology's labeling theory have been used by a number of social scientists to examine people's reactions to health conditions (Ab-lon, 1981), deafness (Becker, 1981), leprosy (Gussow and Tracy, 1968), diabetes (Hopper, 1981), severe burns (Knudsen-Cooper, 1981), and epilepsy (Schneider and Conrad, 1980). These works are likewise useful for theoretical approaches to stigma.

EMPIRICAL STUDIES

The social psychiatric literature contains many empirical studies that deal with different facets of the relationship between stigma and mental illness. Five major "themes" or component parts to this relationship were selected for review, two dealing with non-patients (attitudes toward mental illness, rejection of the mentally ill) and three with patients (conceptions of self, attitudes toward the hospital, posthospital experiences) . In some of these studies researchers tested specific hypotheses derived from Goffman's works and/or labeling theory while in others the topics covered were more general with respect to stigma. Findings pertaining to both types of empirical studies are important here.

Attitudes Toward Mental Illness

The survey method has been utilized for many years to examine public attitudes toward mental illness. Large probability samples of residents in a given community or

city were generally taken, and at times national surveys were drawn. In one group of studies people were asked to respond to different kinds of questions (free-response, forced-choice, agreement-disagreement) concerning the causes, symptoms, or treatment of psychiatric disorder. Another group of studies tested the public's recognition of mental illness via case descriptions of diagnostic types.

Ramsey and Seipp (1948). in one of the first systematic investigations, gathered data with free-response questions from a representative sample of adults in Trenton. New Jersey. They found that most respondents believed mental illness is caused by psychogenic factors (emotional difficulties) rather than supernatural forces (God's punishment for some sin or wrongdoing), is not inherited, and is amenable to treatment. A survey by Woodward (1951) based on a cross-section of residents in Louisville. Kentucky yielded similar results. The questionnaire consisted of structured responses to a variety of questions dealing with different aspects of mental health and illness. The data indicated that there was a more humanitarian and scientific view toward mental illness than previously reported. Notions that the mentally ill were bad or dangerous and should be punished seemed to give way to the belief that mental illness is a sickness that should evoke sympathetic understanding and requires some form of professional treatment.

Cumming and Cumming (1957) conducted an experiment in western Canada designed to change popular attitudes toward mental illness and the mentally ill. A sample of community residents was first interviewed and asked to fill out questionnaires in order to obtain their beliefs. After this, an intensive educational campaign was carried out for six months. Three propositions were stressed in their educational films and group discussions: that the range of normal behavior is wider than often believed, that deviant behavior is not random but has a cause, and that normal and abnormal behavior are not qualitatively distinct. At the end of this period, another sample was interviewed on the same topics to measure any changes in attitudes that had occurred. The experiment proved to be a failure. There was practically no change in the community's attitudes. The townspeople readily accepted the first and second propositions but completely rejected the third. The idea that anyone could become mentally ill under certain circumstances was disturbing because it conflicted with the predominant values of the people in this community. The Cummings' study suggests that initially negative attitudes toward mental illness cannot be modified or changed easily.

A major survey on what the public knows and feels about mental illness and its treatment has been reported on by Nunnally (1961). A nationally representative sample was presented with a series of statements concerning various mental health beliefs, and was required to "agree" or "disagree" on a seven-point scale. The results showed that the average person does not believe in the superstitions and obvious misconceptions about mental illness. Statements such as "Most people who 'go crazy' try to kill themselves" and "There is not much that can be done for a person who develops a mental disorder" were largely rejected by the public. The occurrence of psychiatric disorder was usually explained in terms of pressures in the external environment; when the pressures were mitigated, the emotional disturbances improved. Nunnally also found that the mentally ill were regarded with fear, distrust, and dislike by the general public. The stigma associated with mental illness cut across all social groups, i.e. was not related to such variables as age or education.

Downey (1967) attempted to discover the types of explanations used in identifying mental illness from the points of view of both causes and symptoms. A representative sample of Buffalo, New York, was drawn and respondents had to complete a 30-item "check-list" of possible symptoms and causes of mental illness based on suggestions from the literature. The public perceived as symptomatic of mental illness items of a moral (behavioral deviations, inability to distinguish right from wrong) and interpersonal (dominating. insulting, complaining) nature most often; mental symptoms (poor memory, look in one's

eyes) were thought to be indicative of mental illness much less often. Downey also noted that the public tends to select interpersonal explanations as causes of mental disorders. He claimed that his findings confirm Woodward's prediction that folk beliefs about mental illness are giving way to scientific explanations.

In 1950 at the National Opinion Research Center, Star (1955) developed six case descriptions of mental disorder with the help of psychiatrists. The hypothetical cases corresponded to the following diagnostic types: paranoid schizophrenic, simple schizophrenic, alcoholic, anxiety neurotic, compulsive-phobic personality, and childhood behavior disorder. She was concerned with the public's recognition of psychiatric symptoms, and respondents from a large national sample of adults were asked to designate whether anything was wrong with the people described and if they felt the people were mentally ill. These Star vignettes were also used by Cumming and Cumming (1957) in their study of a small Canadian town and by Lemkau and Crocetti (1962) in Baltimore, Maryland, Meyer (1964) in East-on, Maryland, and Dohrenwend and Chin-Shong (1967) in New York City.

Star found that only the most extremely disturbed behavior was recognized as such by the majority of her respondents, that they tended to resist calling anyone "mentally ill." The Cummings likewise observed that only the paranoid schizophrenic type of disorder was perceived by more than 50 percent of the sample as a case of mental illness. Studies conducted in the 1960s by Lemkau and Crocetti, Meyer, and Dohrenwend and Chin-Shong, however, all revealed that the public's perception of what constitutes mental illness increased. Very large proportions of respondents in these three studies recognized the paranoid type, plus there was a substantial increase in the proportions recognizing the other types. Lemkau and Crocetti interpreted their results in a positive light, as evidence of the triumph of efforts at mental health education.

Rejection off the Mentally Ill

A number of researchers developed "social distance" scales to measure nonpatients' rejection of the mentally ill. These scales generally consist of from five to 15 items to which subjects had to either agree or disagree. The items deal with people's willingness to accept a former mental patient as a club member, neighbor, workmate, roommate, spouse for a child, spouse, etc., or refer to one's inclination to associate or interact with ex-patients. Social distance scales have been given to samples of the general public, professional groups, relatives of former patients, and patients.

The social distance scale constructed by Whatley (1959) tested avoidance reactions to former mental patients. He administered his eight-item scale to a large sample of the general public in Louisiana. The items ranged from those involving minimum ego-involvement (associations with patients) to those with maximum ego-involvement (hire patient as a baby sitter). Whatley found that knowledge of mental illness (visitations to a mental hospital, illness in the family) had no effect on attitudes toward the mentally ill. Respondents were less favorable (more rejecting) on items dealing with maximum ego-involvement, and Whatley concluded that this tendency to stigmatize causes socially unhealthy environments for recovering mental patients. The Whatley scale was later used by Swanson and Spitzer (1970) to test hypotheses derived from Goffman's works. They were interested in how mental patients stigmatize (reject) other patients, how relatives of patients stigmatize the mentally ill, and how the propensity to stigmatize changes during the patient's career phases. Data from three different hospital samples indicated that the propensity to reject the mentally ill was highest in the prepatient and inpatient phases; postpatients' scores on the social distance scale were significantly lower. Relatives' rejection scores were slightly lower than that obtained from patients, and were considerably more stable from one phase to the next. Swanson and Spitzer concluded that, of the two patterns of response by relatives suggested by Goffman, the sharing of the stigma, living within the patient's world, occurs more often than the avoidance or termination of relationships

with the patient.

A different social distance scale was used in a study of feelings of stigma among mothers and wives of former mental patients. Freeman and Simmons (1961) sought a set of items which would reflect the sensitivity of the relatives to reactions of family, friends, and work associates regarding the hospitalization of a member of the household. They observed that 24 percent of the relatives questioned reported one or more of the five stigma problems on the scale. The proportion rose to 45 percent among relatives of patients with "severe" symptoms, but fell to 14 percent when the symptoms were "minor or absent." Thus, although feelings of stigma among family members were not common, they were closely connected with the degree of bizarre behavior on the part of the ex-patient.

Phillips (1963) used his scale in conjunction with the Star vignettes of mental disorder, but replaced the alcoholic type with a description of a "normal" person. Results from a sample of females were tabulated by the help-source utilized: the individuals described were said to have never sought help, or alternatively, to have sought help from a clergyman, physician, psychiatrist, or mental hospital. Phillips found that rejection was greater (social distance scale scores higher) for the psychotic types of illness than the neurotic, and individuals are increasingly rejected as they seek psychiatric help. He concluded that the utilization of certain help-sources involves both a reward (potential mental health) and a punishment (rejection by others and a negative self-image). The Phillips study was replicated by Schroder and Ehrlich (1968) with a sample of psychiatric nurses. They too observed that case descriptions of psychotics were rejected much more than those of neurotics, but rejection scores did not vary according to help-source. Their data suggested that among people with psychiatric training and experience, the crucial variable explaining the pattern of rejection is less the seriousness of an individual's mental illness than the appropriateness of the help obtained. Bord (1971) also repeated the Phillips study and extended the design to include a third variable, the occupational status of the individual. With a sample of college students, Bord found, as hypothesized, that those with a high status were rejected less often, especially the paranoid schizophrenic and anxiety neurotic types. He interpreted this to mean that the major determinants of rejection are the perceived unpredictability and danger of the behavior in question. Bord disagreed with Phillips and claimed that the increasing rejection from different help-sources does not signify additional stigma but rather additional information regarding the seriousness of the described behavior.

Kirk (1974) studied the influence of labeling on people's reaction to the mentally ill. He employed three case descriptions, Star's paranoid and neurotic types plus Phillips' normal person, in conjunction with a 15-item social rejection scale (with some items borrowed from Phillips). Each of the three vignettes of behavior was given to a large sample of college students in 12 different versions. Kirk systematically varied the label (behavior explained as due to mental illness, wickedness, or stress) and the labeler (labels offered by self, family, some people, or psychiatrist) . The findings revealed that neither the label nor the labeler significantly affected the degree to which the mentally ill were rejected. Only the behavior itself was correlated with rejection scores; less disturbed behaviors yielded greater degrees of individual acceptance. Kirk claimed his data suggest a key component of labeling theory (Scheff's propositions on people's reaction to labeled mental illness) should be de-emphasized.

The public's acceptance of former mental patients was tested by Farina, Murray and Groh (1978) without the use of social distance scales. They set up an experiment to see how a "job applicant," a confederate of theirs, would be evaluated by workers on the job. The workers were told that the applicant was either an ex-mental patient or an ordinary person, and for each condition the confederate was either calm for half of the subjects or was nervous. Women were discovered to be more accepting of former patients than men on a postexperimental questionnaire. Men were more accepting of

female than male ex-patients. Nervous applicants were rejected by workers of both sexes.

Conceptions off Self

Studies of patients' conceptions of self concern one of the most important facets of the relationship between stigma and mental illness. Goffman's whole theory of stigma reposes on the notion that discredited people have a lowered self-esteem and undergo a change in social identity, and labeling theory contends that hospitalized patients lose normal social roles and internalize the role of the mentally ill. Unfortunately, fewer researchers investigated self-conceptions than other topics dealing with the stigma of mental illness. And since different methods were used to test patients' opinions, direct comparisons across studies cannot be made.

Giovannoni and Ullmann (1963) asked male patients at a veterans hospital to complete the semantic differential for the concept "Me," seven-point ratings for 17 adjective dimensions. On most dimensions, there were no significant differences between patients' ratings and comparable data from nonpatients; however, patients rated themselves as less active and less healthy. Harrow et al. (1968), with a sample of adolescents and young adults at a university hospital, favored 50 Q-sort items rated on nine-point agreement-disagreement scales. Patients' conceptions of self one and a half weeks after admission were significantly more negative than those of matched controls. Seven weeks later there was a significant increase in patients' self-image scores. In another study at the same psychiatric facility. Harrow. Fox and Detre (1969) gave their test instrument to an adult population. Patients' initial views of themselves were significantly more negative than their views of their spouses. After eight and a half weeks of hospitalization, patients' self-images had become significantly more positive and were similar to their views of their spouses.

To empirically examine Goffman's concept of self-mortification, loss of self-hood in the mental hospital. Karmel (1969) used a measure of self-esteem (ten item agreement-disagreement scale) and a measure of social identity (20 unstructured answers to the question "Who Am I?") with patients at a state institution. The findings showed that patients registered slight gains in self-esteem and social identity rather than substantial losses. Karmel speculated that self-mortification did not occur because of the difference in perspective between patients and outside observers of mental hospitals (notably, Goffman). What appears humiliating and role-dispossessing to an outsider, she said, may not be the way patients see it at all. In another study, Karmel (1970) categorized patients' unstructured responses in a different manner, in order to test propositions from labeling theory. She found that during the first two years of hospitalization there was a definite decrease in the patient's "home world" social identity, but there was not a corresponding increase in "hospital world" identity. Thus, patients did experience certain loss of normal social roles as a result of institutionalization but did not acquire (as Scheff maintained) a social identity based on their deviant social role.

Teichman, Bazzoui and Foa (1974) explored patients' changes in self-perceptions following short-term psychiatric treatment on a mental health center ward. Patients' attitudes towards themselves and their spouses (approval or disapproval of reciprocal role behavior) were measured via a semi-projective test of 96 items. They learned that before treatment both neurotics and schizophrenics rejected themselves, socially and emotionally, much more than they did reject their spouses. After treatment, the neurotic group revealed a marked reduction in the difference between their perceptions of self and spouse, while the schizophrenic group's mean scores did not differ significantly. Although positive changes were noted for neurotics, at discharge they continued to see themselves less favorably than they saw their spouses.

Attitudes Toward the Hospital

In theory, mental patients should feel stigmatized and harbor "negative" attitudes toward their own institution or hospitals generally. Goffman (1961) contends that patients

commonly sense that hospitalization is a massive unjust deprivation, that all patients feel some downgrading in the hospital. Scheff (1966) claims that patients become extremely indignant and angry when they do not wish to be hospitalized but are forcibly treated, that psychiatric treatment convinces patients they are "sick," and that there is considerable pressure on patients to accept the ignominious role of the mentally ill. In addition, Clausen (1980) notes that the stigma associated with mental illness seems inevitable in a society that values instrumental achievement, and hospitalization greatly accentuates a sense of role failure in patients. Such theoretical statements, often based on qualitative data, can be checked against results from quantitative studies of patients' attitudes toward mental hospitals (Weinstein, 1979).

Souelem (1955) constructed an attitude scale comprised of 72 agree-disagree statements and gave it to patients at a state and veterans' hospital. She found that the majority of patients at both institutions scored in the favorable end of the scale, approximately 85 percent being above the midpoint. The Souelem scale, which measures attitudes toward mental hospitals in general, has been used by other researchers in different institutions (Klopfer, Wylie and Hillson, 1956: Imre, 1962; Roback and Snyder, 1965). In these studies, patients proved to be favorable in orientation as well.

Attitudes toward hospitals generally were also examined with other measures. At a private psychiatric facility (Toomey et al., 1961) patients were largely neutral in attitude when tested with the less conscious techniques (projective and sentence completion tests) but favorable with the more conscious techniques (multiple-choice questions. Souelem scale). At a university hospital (Jones, Kahn and MacDonald, 1963) patients responded positively to all four statements on the stigma of hospitalization. They tended to disagree that people who have been to mental hospitals are peculiar or treated differently, and strongly disagreed that they are undesirable socially or not wanted by family or friends. At a state institution (Levinson and Gallagher, 1964) patients' scores on two factor analytic scales suggested ambivalence toward the hospital. A number of investigators measured patients' opinions of their own institution. Small, Small and Gonzalez (1965) questioned patients on admission to a city hospital and again at discharge as to why they came there and whether it was a wise decision. Initially, an equal proportion of patients accepted and rejected their hospitalization, but before being released a higher proportion indicated acceptance. The study by Linn (1968) at a state hospital revealed clearly that most patients hold favorable attitudes. Of the patients interviewed at the time of admission, 55 percent said they wanted to come to the hospital, 54 percent were not forced to come, 63 percent had no fears of being hospitalized, 75 percent did not feel betrayed by friends or family (a point emphasized in Goffman's 'Asylums'). 58 percent did not expect any loss of individual rights, and 53 percent did not expect a poorer reputation at home. At a university hospital, Goldstein et al. (1972) asked patients at discharge to evaluate the hospital milieu. Patients' scores were above the mean, on the favorable side, for five of the seven items. Mayer and Rosenblatt (1974) elicited patients' views of their state institution via six-point agreement scales for 15 statements. In ten cases patients' mean scores were on the better side of the midpoint. Patients complained mainly about the organizational problems of the mental hospital (e.g. meals, equipment repairs, thefts, programs) but were quite satisfied with the therapeutic aspects (doctors, rest and recreation, patient meetings, restrictions, discharge policy).

Posthospital Experiences

The experiences and interpersonal relations of patients after discharge from a mental hospital are crucial for any discussion of stigma. According to the theory, former patients should encounter rejection from other people, feel ashamed at having been institutionalized, have difficulty in enacting social roles, and possibly even nurse resentment toward the hospital. Several studies over the years have dealt differently with the behavior

and attitudes of ex-patients in the community.

Freeman and Simmons (1958) were concerned with the "performance levels" or posthospital activities of male patients. The six-point work performance scale measures the continuousness of patients' employment since discharge, while the social performance scale taps the degree to which patients belong to voluntary associations, attend meetings, and visit with or are visited by other people. They discovered that patients' level of performance was correlated strongly with family setting. Patients had much higher work and social participation scores when they were living with conjugal rather than parental families. However, rehospital-ized patients were much more likely to have come from conjugal settings. Freeman and Simmons (1961) concluded that mothers, compared to wives, are much more likely to tolerate deviant behavior and that patients in parental settings are free of many of the stresses that husbands would encounter.

A few other studies dealing with post-hospital performance or behavior are worth citing. Small. Small and Hayden (1965) found that fewer emergency room visits and fewer rehospitalizations in the year and a half following discharge were characteristic of those patients who registered a positive change in attitude between admission and discharge: those without a shift in opinion performed more poorly. Gove and Fain (1973) surveyed the experiences of a large sample of ex-patients one year after hospitalization. They found that patients showed a decided improvement in their relationships with cohabitants (self-evaluations of how well they got along) and modest improvements in their instrumental performance (employment status, financial position, housewife role) and community activities (visits with others, time devoted to recreation, participation in formal organizations). Gove and Fain believe the stigma of mental hospitalization is not a major problem for most patients. Huffine and Clausen (1979) studied married men who first entered mental hospitals in the 1950s via follow-up interviews in the 1970s. Men who developed competence in their work roles prior to the onset of illness were likely to retain their jobs through the initial episode of illness and to remain occupationally stable in the intervening years, even in the face of persistent psychiatric symptomatology. They conclude that the label "mental patient" does not constitute a master status and. in and of itself, does not significantly affect occupational careers.

Former patients' feelings of stigma or rejection and evaluations of hospital treatment are likewise important components of their posthospital experiences. Cumming and Cumming (1965) learned that 41 percent of the ex-patients they interviewed expressed shame at having been in a mental hospital or had a generalized expectation of discrimination. No differences were found in feelings of stigma by age, work status, or education, but diagnosis was related. Neurotics had the highest stigma score, schizophrenics the next highest, and manic-depressives the lowest. Nuehring (1979) measured the degree of social stigma experienced by discharged state hospital patients. On the Stigma Index (three-item agreement scale dealing with avoidance reactions), with a possible maximum score of 12. patients scored 6.2 and clustered closely around the mean. Social, demographic, and psychiatric factors, as predictors of stigma, accounted little for the variance in scores. Thus, in this study, there was a moderate degree of stigma experienced by ex-patients. Gove and Fain (1973) reported that most (83 percent) of the ex-patients they tested claimed that mental hospitalization was beneficial to them: only a few said it had been detrimental, and less than half of these expressed concern about stigma.

EVALUATION AND CONCLUSIONS

Studies dealing with attitudes toward mental illness suggest that the public is fairlv well-informed. People correctly perceive that emotional difficulties, interpersonal conflicts, and environmental pressures are the chief causes of psychiatric disorders, and they easily recognize the textbook symptoms. And folk conceptions of mental illness (God's punishment, untreatable) are being replaced by scientific explanations.

However, the public still sees mental illness in a negative context. Educational campaigns seldom change attitudes for the better, and the mentally ill are feared and distrusted. Definite conclusions as to how favorably the public envisions mental illness can thus not be made. This is evident from a more complete review of this literature by Rabkin (1974). She contrasted the series of studies that reported optimistic findings (claims that the stigma associated with mental illness has decreased over the years) with those that presented pessimistic results, and concluded that although the public now has more positive attitudes than in the past a major proportion of the population continues to be re pelled by the notion of mental illness.

Data from the investigations on rejection of the mentally ill more strongly point in a single direction, viz. that the public tends to stigmatize those persons with psychiatric symptoms or those who have been to a mental hospital. This rejection, however, is apparently greater for persons manifesting more disturbed behavior (psychotics. those with severe symptoms, those affecting nervousness) and in situations of more personal involvement (marriage, baby sitting). Rejection also appears to be greater when it is being done by the general public rather than by relatives of patients. It should be pointed out. however, that there is controversy over the social distance scale studies. Brockman. D'Arcy and Edmonds (1979) maintain that the methodological techniques of the studies reporting positive findings (less rejection) are more "suspect" than those used in studies with negative results, but Roman and Floyd (1981) argue that the conceptual structure underlying these studies indicates bias in favor of rejection and the negative data can be interpreted as reflecting a high degree of acceptance. This merely underscores the difficulty in using attitudes, as measured by abstract cases, to make inferences about people's actual behavior. Even studies like the one by Farina, Murray and Groh (1978). which measured rejection of the mentally ill by a paper-and-pencil test although with real cases, may not truly indicate how much and what kind of stigmatiza-tion would actually occur.

The theory of stigma vis-a-vis patients' conceptions of self is seriously questioned by the studies reviewed here. In two investigations specifically designed to test Goffman's ideas and the labeling perspective. Karmel has amassed considerable evidence that institutionalization does not produce self-mortification, nor does it lead to the acquisition of a deviant social identity although some normal social roles are lost. Other more general investigations indicate there are no significant differences between patients and nonpatients in self-conceptions, or that when there are differences patients tend to change for the better during hospitalization and perceive themselves more nearly like nonpatients. Stigma theorists seem to have overstated the degree to which hospitalized mental patients shed their former identity and conform to the stereotyped role of the mentally ill.

Quantitative data on patients' attitudes toward the hospital also question the theoretical positions of Goffman, Scheff and others. Contrary to what most people would expect, patients are largely positive, or at least not negative, in their opinions of their own institution or hospitals generally. Patients are not bothered very much by conditions in the hospital or the possibility of rejection after discharge, and believe they benefited from treatment. Essentially, theorists studied the mental hospital from the patient's view via qualitative methods (informal interviews, observations, masquerades as patients) and this probably accounts for the different results reported. A number of quantitative researchers (Linn. 1968: Karmel. 1969: Gove and Fain. 1973: Wein-stein. 1979) have contended that such qualitative data are biased, inaccurate, or onesided.

Data from studies of patients' posthospital experiences seem to point in more than one direction regarding the stigma or difficulties they presumably should be encountering. On the one hand, findings relating to performance levels and social behavior suggest that the theory is wrong. Patients after discharge showed improvements in their relationships with other people and ability to perform normal social roles, and were capable

of remaining occupationally stable. On the other hand, results dealing with patients' feelings of rejection intimate that the theory is, to some extent, correct. In two studies about half the patients questioned claimed stigma was a real problem for them, but in one only a few patients felt this way. Thus, while many former patients can function fairly well in the community, they still have apprehensions about their performance and expectations of rejection.

The theory of stigma appears to apply more to nonpatients' attitudes toward mental illness and the mentally ill than to patients' hospital and posthospital experiences. In the public's mind, psychiatric labels evoke negative emotions and avoidance reactions. This, however, is quite "normal" as all societies devalue disturbed behavior and those with psychiatric symptoms, and all societies stigmatize that which is devalued. In the patients' minds, their own illness and hospitalization summon far less discrediting characteristics, rejection encounters, and reduced self-images than the theory of stigma purports. This, too, is not unexpected as most patients come to the hospital for help with emotional or interpersonal problems and conventional wisdom tells us that they would normally do all they can to maintain a positive social and personal identity. Goff-man's and Scheff's theories thus have credence if the public's unfavorable opinions on surveys are indicative of their stigmatizing actions. Inasmuch as the relationship between attitudes and behavior is a highly complex one. and social research has not unequivocally demonstrated that what people say they would do in a given situation corresponds to what they actually would do if the situation arose, then the theories may need to be qualified. With respect to the reality of patients' hospital and posthospital attitudes and behavior. Goff-man's and Scheff's theories definitely need qualifying.

The stigma of mental illness is real. There are negative attitudes toward and rejection of the mentally ill. But the stigma is not as great as the public may believe, and it is not nearly as great as the theorists have claimed. The exact nature of the relationship between societal tendencies to stigmatize the mentally ill, patients' fears of stigmatization, and patients' abilities to overcome real or imagined stigma has yet to be delineated. Perhaps this should be the topic of the next conference on stigma and mental illness.

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