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Mental Health Education in A Canadian Community

John Cumming and Elaine Cumming

ABSTRACT

The experiment described here was aimed at changing negative attitudes of the public toward the mentally ill. An intensive educational campaign about mental health was conducted in a small community in western Canada. Before-after questionnaires were used to determine what effect the campaign had on attitudes toward the mentally ill. The tests showed no appreciable changes in beliefs about mental illness or attitudes toward the mentally ill as a result of the program. The unanticipated hostility that was generated by the project is discussed. This piece originally appeared in 1955 Health, Culture and Community.

The Problem: Unexpected Outcome of an Educational Experiment

In 1951 an experiment in altering popular attitudes toward the mentally ill was launched in Prairie Town, a community in a western Canadian province. The project grew out of a desire on the part of the province's Department of Public Health to extend its usefulness by entering the field of preventive psychiatry. We who were working in the psychiatric division of the Department pondered how to make a beginning in this direction. One possibility considered was that of early case-finding. But, our mental hospitals were already overcrowded and our recently established outpatient clinics had long waiting lists of people eager to be helped.

A more appealing plan, we reasoned, was to develop a program of education that would give people in the community a better understanding of mental illness

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and of current knowledge about child development, delinquency, and allied subjects. In the long run such an educational program might possibly decrease the incidence of mental illness. Whether or not this would prove true, it did seem that bringing about a more tolerant popular attitude toward those who had been in mental institutions might well speed the process of psychiatric rehabilitation and lower the high relapse and readmission rate. Discharged mental patients usually encountered a generalized attitude of fear, suspicion, and rejection when they returned to their community. Our public health nurses knew this from their efforts to help former patients readjust to their home surroundings, and we knew it from stories told us by former patients.

Aided by a generous grant from the Commonwealth Fund, we carried out the Prairie Town experiment. We prepared the ground slowly and carefully. Then for six months we utilized all local facilities in a concerted effort to bring about a measurable change in attitudes toward the mentally ill. By means of questionnaires and interviews we tested a sample of townspeople twice, once at the beginning of the intensive campaign and again at the end. After our educational experiment was over, we had time to analyze and compare the two sets of test material. The tests showed that no significant change in attitude had occurred.

We had been unable to effect any evident change in attitudes toward the mentally ill. Attitudes toward us, on the other hand, had undergone a very evident change. The people of Prairie Town, initially friendly and cooperative, had become increasingly aloof as the months went by, despite every effort on our part to be tactful and friendly. From apathy they resorted to withdrawal, and when our interviewers returned to Prairie Town at the end of six months to administer the retest, they were dismayed at the outright antagonism they encountered. Our well-intentioned efforts to alter attitudes had apparently produced side effects that we had not bargained for. What was the connection between the negative outcome of our educational program and the positive hostility that was aroused? What does this connection reveal about the needs served by popular concepts of illness?

The Situation: An Effort to Alter Mental Illness Concepts

The Community of Prairie Town

Prairie Town is located about 50 miles from Prairie City and was chosen mainly for reasons of convenience. It can be reached both by transcontinental railroad and by a good highway which is kept open and free from snow all winter, an important consideration in this part of the world. This area of the province is mainly Anglo-Saxon in origin, and Prairie Town is an old and stable community. Thus, project workers did not have to deal with language difficulties or a shifting population.

Prairie Town is mainly a distributing center. Many residents are farmers who own homes in the town as well as farmsteads in the surrounding area. Most residents have lived in the town for many years; many were born there. It is a wealthy town for this part of the country, proud of its modern facilities, including sewer and water systems, which are unusual for a prairie town of 1,350 persons. People of Prairie Town are essentially conservative and individualistic. When the library board canvassed the town for donations for a small building to house the library, they could not raise the necessary \$400, despite the fact that three people in town are reputedly near millionaires. One of these said to the canvasser, "If people want to read books, let them buy them themselves." The town has one movie house and a weekly newspaper. Community recreational facilities are poor. Both the grade school and the high school are old and inadequate, in marked contrast to Prairie Town's many fine homes with well-kept grounds. Many streets are lined with stately trees, carefully planted and cared for, something seldom found in other prairie towns. Most of the better homes have large flower gardens, and local pride in the appearance of the town is reflected in the commonly used slogan, "Prairie Town, the beautiful."

However, when Prairie Town citizens use this slogan, they do not mean to include that part of town known as Germantown. Germantown contains no Germans but was so named, according to a local story, during World War I, when the term "German" was applied to any unpopular group. Germantown is a collection of tiny wooden and tar-paper-covered houses on the east side of Prairie Town. It is inhabited mainly by Metis, a French-Indian cross comprising about 5 percent of the population, and by a few other economically depressed minority groups. Germantown families are not served by the sewer and water facilities of which Prairie Town is so proud. Prairie Town is a wealthy town, but it is also a town of contrasts.

In Prairie Town there are a large number of organizations, social clubs, church groups, choirs, sports clubs, service clubs, and fraternal organizations. A local agricultural agent who proposed building a community center surveyed these groups and counted more than 70 organizations. The groups show a high degree of overlap in membership and direction, but there are also many people in town who belong to only a few organizations or to none. The town is set off from others around it by two government agricultural and experimental stations. Personnel from these installations contribute a small group of highly educated persons in Prairie Town's population. These people have a social life largely confined to their own numbers and, while respected by the townsfolk, they are not included in the informal groupings of the town.

Our survey revealed two main types of people in Prairie Town. One segment of the town places a high value on the puritan virtues: honesty, hard work, thrift, good housekeeping, and a God-fearing religious life. The values of the other segment, more educated and better housed, center on community service; men of

this group want to be known as good mixers and proficient businessmen and prefer that their wives be active in community affairs as well as proficient in housekeeping.

A Mental Health Educational Campaign

In planning the educational campaign before coming to Prairie Town, we had postulated that people tend to reject the mentally ill because of fear, ignorance, and guilt. Experience has shown that the average layman thinks that most persons who become mentally ill are violent; this is believed not only by those who have had no direct contact with the mentally ill but also by many who have. The latter seem to accept the general belief rather than trust their personal experience.

In addition to this explicit fear, we thought, people may have a less conscious fear of becoming mentally ill themselves, since causative factors are so general and so imperfectly understood. This fear may be created by a little knowledge. We found, for example, when teaching student nurses in the psychiatric department of a general hospital that they had a great deal of anxiety because in some respects they could see little difference between the mentally ill and themselves, and because they could find in themselves many of the psychological mechanisms used to explain mental illness.

Many people who have placed friends or relatives in an institution feel relieved at being absolved of their responsibility. To acknowledge that such institutions are socially undesirable or physically inadequate would provoke a sense of guilt; the easier course is to remain blind to the facts. Relatives of mentally ill persons often keep reassuring themselves that institutional care is "the best thing" for their relatives, and that the institution in question is at least "better than most others." Another way to redirect guilt is to attribute to minority groups traits about which the "projecting" individual feels ambivalent. This mechanism is well known in racial prejudice, and we assumed it to be partly responsible for some of the distorted concepts about the mentally ill. We reasoned that some of the violent impulses attributed to the mentally ill might in fact be projections of a normal person's unconscious urges.

On the assumption that misconceptions about the mentally ill were tied in with deeper emotions such as fear and guilt, we regarded the task of community education as a delicate undertaking. We would have to avoid assuaging some fears at the cost of arousing others. For example, if we were to stress the point that mental hospitals, contrary to widespread sentiment, are not an ideal setting for inducing recovery, we might thereby increase the amount of guilt felt by those with hospitalized relatives.

We knew that we would often be questioned on the nature of mental illness, the characteristics of the mentally ill, conditions in mental hospitals, and treatments for these disorders. To evade these questions would in itself produce

suspicion and anxiety; therefore, we decided that when they did arise they should be answered honestly, sympathetically, and with a minimum of sensationalism.

We undertook to teach three basic concepts: first, that there is a very wide range of human conduct that can be considered "normal"; second, that behavior does not "just happen" but has determinate causes and can therefore be understood if one knows the factors involved; and third, that the borderline between "abnormal" and "normal" is vague and arbitrary.

Although our primary backing came from the provincial government, it was decided that we would align the program with the Canadian Mental Health Association, a voluntary nonprofit organization, so that we would not be considered an agency of government. We expected Prairie Town to be a conservative town where there would be a great deal of opposition to the liberal ideas of the current government. We used as a rationale for entering the community the idea that we were trying to establish what the term "mental illness" meant to a group of typical citizens. The project team included a psychiatrist and a sociologist as senior workers, and six trained interviewers. Some of these personnel stayed in Prairie Town for extended periods of time, and others came to the community from their base in Prairie City when their special services were required.

Initial contacts in the community were established without too much difficulty. On a bright day in late August we drove the 50 miles from our Prairie City base to Prairie Town. Our first stop was at a local store, whose owner we already knew. We explained to him that we were interested in learning what the townspeople thought about the mentally ill. During our discussion, he posed a question which we were to hear many times: "Why do you want to know what we think? Why not go to the experts?" To this question we developed a standard reply: We countered with the question, "Who sends people to mental hospitals?" In answer, people usually placed the responsibility on the local doctor, but when we then asked why the mentally ill person had been taken to the doctor in the first place, they usually recognized that the ultimate responsibility rested with the family and neighbors of the ill person. We told the storekeeper that many experts felt that some of the patients in mental hospitals might not be as ill as those who remained harmlessly in the community, and pointed out the role of community beliefs and attitudes in bringing about the situation.

From the storekeeper we got a list of people who were influential in the community. The list included not only town officials but many executive officers of local clubs and organizations. Over a period of about a week we called on each of them. We talked about our survey, asked for permission to attend their club meetings from time to time, and volunteered to help plan their programs for the coming winter. Their response, in general, was polite and friendly, but they seemed a little puzzled. They accepted our purposes intellectually but had difficulty

understanding why we wanted to collect information without any immediate practical use in mind. We did not yet realize that very few people consider this type of research to be a normal occupation.

When our initial rounds were completed, we had a chat with the proprietor of the local weekly newspaper and gave him a release concerning our program. He promised to cooperate and in the months that followed gave us wholehearted assistance. News stories and articles we furnished appeared in his paper almost every week, in addition to paid notices advertising various facets of our educational program. The proprietor also gave us editorial support on several occasions.

We tried to reach as many people as possible. We used all means and resources usually called into play in such campaigns: motion pictures, pamphlets, special books placed in the local library, notices in the local newspaper, radio broadcasts, speakers, and small group discussions with competent discussion leaders. Not wishing to make this an impractical experiment, we included no items in our program that could not be obtained by an interested and informed citizenry at a cost within their local means. While we promoted a great deal more mental health activity than has ever before been induced in a community of comparable size to our knowledge, a similar educational campaign could be produced again without calling for special outside funds.

The first group to become interested in our program was the local Parent-Teacher Association. The president of the group invited us to its first executive meeting, during which the forthcoming winter's program was to be planned. We attended two executive sessions and were disappointed to find that the quorum necessary for decisions was not present at either meeting. We felt that this was partly due to the fact that the P.T.A. was a new and relatively weak organization, but we were soon to find this pattern of reaction recurring as we met with other groups and executives. We began to believe that the whole town was suffering from some sort of apathy. Only later when we saw the energy and enthusiasm devoted to other town projects did we realize that this "apathy" was in some way connected with what we were trying to do.

Later on, however, the P.T.A. became a source of strength to us. It accepted our help in planning the winter program and joined us to co-sponsor a three-day festival of educational films on child care. It also did a good deal of work in helping us produce a series of 12 half-hour radio programs in which local children and adults held panel discussions on children's problems. These programs were popular and had a good listening audience.

Community "apathy" was evidenced in other situations. Some local citizens felt it might be useful to form a group to discuss the development and mechanisms of human personality. We were quite eager to help with this. First, we discussed the idea informally with a few people and then called a meeting to discuss the formation of such a group. It was decided that the theme of the discussions would be "Why I am as I am" and that the group should meet every second week

throughout the winter. Several came to the organizational meeting without specific invitation; fourteen persons were present. Enthusiasm seemed to be high and almost everyone claimed to know of others who would be interested. Expecting a large turnout, we arranged for two other specialists from Prairie City to attend the first meeting so that the participants could divide into small discussion groups with one informed person in each group. When we arrived at the rather large meeting room, we found a total attendance of five persons. Although this group eventually grew larger, the small initial turnout typified community response to our educational efforts.

Another form of "apathy" was evidenced during the history of this discussion group. Peak attendance at meetings grew to about 35, but with the exception of a few faithful participants, the composition of this group was constantly changing. Thus, five or six newcomers would be present at each meeting, and five or six who had attended previously would be absent. This same pattern occurred at meetings of other groups, although it was more pronounced in this group that continued to meet throughout the winter.

It became apparent that our use of written material was not very successful. The local newspaper, as noted, was especially cooperative and printed whatever material we furnished. However, there was little evidence that these stories were widely read. Similarly, the demand for the pamphlets we offered at meetings and advertised in the newspaper or on the radio proved to be very slight. It seemed that the citizens of Prairie Town were not a pamphlet-reading people. On the other hand, about a dozen popular books on mental health topics we placed in the local library had a very good circulation as compared with the usual rate for new books. The library board, incidentally, felt that any more books on mental health would have caused an imbalance in this direction. Perhaps with some justice, the board has classed these books with those donated by various religious organizations setting forth their doctrines.

Apathy, Anxiety and Hostility

The sparse attendance at meetings, the rapid turnover of discussion groups, and the apparent neglect of our printed educational materials—all these we at first attributed to apathy. As the program progressed, however, we began to realize that what we had interpreted as a general lack of interest in our message and as indifference to our program was actually something very different and far more active. The educational program itself was creating unrest and anxiety. When we first came to Prairie Town, the people were polite and friendly. These attitudes changed slowly and subtly; only in retrospect were we able to put together certain incidents and events as evidence of mounting anxiety.

As already indicated, on entering the town we had told people that our object was to learn what an average community thought about mental disease.

In retrospect, we believe that few of them were completely satisfied with this explanation. One way of expressing their puzzlement was to joke about our stated purpose. One man said, "Well I guess you're here because you found out we're all crazy."

The next evidence of the community's discomfort at our presence was a series of rumors that swept the town. One was that "the government" had sent our research team to investigate attitudes toward mental illness because "they" were thinking of building a new mental hospital in Prairie Town. This rumor, while quite unfounded, was not unreasonable in light of the avowed purpose of our program and the content of the questionnaires. The next rumor was less logical: the survey was said to be a "plot" of the Roman Catholic Church. The grounds for this rumor were difficult to find; the local Catholic clergy was definitely, if not actively, opposed to our program. The only possible basis we could see was the fact that a member of the Parent Teacher Association, which was working with us, was a Roman Catholic. About 15 percent of Prairie Town is Roman Catholic.

The faltering attendance at the citizens' study group and the lack of enthusiasm for other aspects of our work have already been cited. As the months went by, people increasingly claimed that "other interests" took precedence over those of our program. One man, asked why he ceased attending an activity sponsored by the project, said, "People say there's nothing to do in Prairie Town, but you could keep going morning, noon, and night if you belonged to everything." During the latter part of the program, we helped a local organization sponsor two very good commercial films, one of which dealt with a mental health topic. Ordinarily Prairie Town attends its local theater faithfully. Since the proceeds of the showing were to go to the local sponsoring organization, representatives sold tickets from house to house. There was no competing event in the town, but despite this the theater was less than half full, an attendance smaller than would be expected from an ordinary poor film on a bad night.

During the early part of the program, the Civil Servants' Association requested us to provide a speaker for one of its meetings. We decided to show the group an educational film on mental health called "Breakdown," made by the National Film Board of Canada. The main incident of the film is the sudden schizophrenic breakdown of a young woman of twenty-three. Knowing from previous experience that the film disturbs some viewers because the heroine's breakdown seems to be "uncaused," we decided to counteract the anxiety thus aroused by conducting a discussion immediately afterward to explain the cause of the breakdown. Although these discussions were held, the Association voted at its next meeting not to have any more mental health films or speakers, despite a previous commitment to present a series of mental health programs.

The most dramatic evidence that our educational program was generating anxiety came from a local citizen who had been closely associated with the project. June was an intelligent, alert woman of about thirty-five. She was very active in

civic affairs and had been instrumental in forming the P.T.A. in Prairie Town. From the start of our project she welcomed our aid in planning P.T.A. programs, and as time went on became more involved with the activities and materials of our campaign. She had done a great deal of voluntary work, and when the pace of our program was accelerated in midwinter, we decided to employ her as a paid part-time worker. In late winter she became upset. She began to warn us that it would be better if we stopped certain educational activities, saying that they had "run their course" and that "everyone is so busy at other things." Shortly afterward, our staff headquarters in Prairie City received several urgent long distance calls from June. She became so highly agitated that it was necessary to admit her to a psychiatric unit where she was given intensive treatment for a state of acute anxiety. In retrospect, we feel that her association with our anxiety-producing program had caused tension between her and her friends, which had led to her temporary instability.

Not until the program reached its end did the increasing anxiousness of the people of Prairie Town manifest itself in overt hostility to our project. When the interviewers returned to Prairie Town at the end of six months to conduct the second interview of our before-and-after series, they were disconcerted by the coldness of their reception. Those interviewed were guarded and cautious. They asked questions such as this: "What happens if I give the wrong answer?" Some kept threatening to break off the interview. One man of considerable influence in Prairie Town, who was scarcely involved with any phase of our program but who had noted its general effects, said to us, "You've sure got this town by its ear." He added that he was amazed at the intensity of the excitement and anger in the community. There is little doubt that the people felt our project was directly responsible for June's temporary breakdown.

Not only did the interviewers meet with reluctance to cooperate, but with active and angry refusal as well. They had been in Prairie Town only a few hours when the wife of one of the original members of the study group telephoned and declared curtly that she did not wish to be interviewed, refusing to give any reason. Shortly afterward her husband, an agricultural scientist who had been an early and active member of the study group, telephoned us and similarly refused to be interviewed. We told him that he had no reason to assume he would be interviewed again since our reinterview sample was different from the original sample. This assurance had little effect. In ten minutes he burst into the hotel room occupied by the project staff and said angrily, "Withdraw my name from anything you have it on." We again declared we would not involve him in any way and asked why he felt as he did. "There's no reason," he said. "I'm just not interested, let's put it that way—I'm just not interested," and left abruptly.

Finally, as if representing the feelings and wishes of the community as a whole, the mayor of Prairie Town approached one of our interviewers and

inquired what he was doing there. He proceeded to question him at length as to his credentials and his right to conduct the interviews. Then he 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." Although the mayor was finally mollified, it was evident that we had worn out our welcome in Prairie Town! It is significant that it was not the education team who felt this hostility but the interviewers, who were virtually unknown in the town. Thus, there appears to have been hostility to the material rather than to the people who carried it.

At the end of our educational program, when both the attitude questionnaire and the intensive interview were administered a second time, there was some falling off in the number of people returning the questionnaire, but it was not enough to bias the results to any appreciable extent. Similarly, fewer people were willing to submit to the interview on this second occasion, but our sample was not significantly affected by this difference. Results were surprisingly clear-cut. After an intensive educational campaign of six months, virtually no change had occurred in attitudes toward or beliefs about the mentally ill.

It could not possibly be argued that we had not touched our community, that our message had simply failed to reach the 900 adults in Prairie Town. The intensity of response to our program was amply evidenced by the man who commented, "You've sure got this town by its ear." The widespread and openly manifested hostility that greeted our returning interviewers could scarcely betoken indifference or ignorance. The people of Prairie Town knew we were there, knew that we were trying to change their ideas, and refused stubbornly and actively to accept that change. It was evident that we had been trying to change ideas that were very deeply and firmly held and that the more energetically we tried to dislodge them, the more tightly people held onto them and the angrier they became at us for trying to take them away.

The results of the attitude questionnaires and interviews, systematically analyzed after we had left Prairie Town, revealed that some of our efforts had been misdirected. The primary purpose of giving tests before and after the educational campaign was to ascertain whether and in what respects our experiment had succeeded in changing popular attitudes concerning mental illness. As it turned out, the interview material also served another purpose: it supplied clues that enabled us to understand why our attempts had incurred hostility. What did the test show?

Attitudes Toward Mental Illness

After we had become well accepted within Prairie Town and before beginning our educational program, we persuaded several local groups to help us distribute a two-page mimeographed paper-and-pencil questionnaire. One Monday afternoon a copy of this questionnaire for each adult was distributed to

every house in town. The volunteers also distributed a reprint of an editorial from the local paper urging cooperation with our project. Later that evening the same group picked up the filled-in questionnaires.

At about the same time, a group of six psychologists and social workers trained as interviewers administered a long interview schedule to a carefully randomized sample of 100 adults. The interview schedule was much more intensive than the questionnaire and sought information on a wide variety of topics relating to mental illness. The interview schedule was developed by the National Opinion Research Center of the University of Chicago under the direction of Dr. Shirley Star and has been administered in the United States. The interview reached fewer people but at a deeper level than the questionnaire. The two research instruments, when the data were later analyzed, produced a fairly detailed picture of how the people of Prairie Town felt about the mentally ill.

The questionnaire was answered and returned by 540 people, or about 60 percent of the adult population. It consisted of a number of yes-or-no questions on two topics: whether people were willing to associate with those who had been mentally ill and under what circumstances; and whether they felt in any way responsible for causing mental illness or caring for the mentally ill.

Answers to the questions on willingness to associate with former patients revealed wide variation in attitudes, roughly corresponding to the different social and economic positions of community members. In general, the community-minded people—who tended also to be younger and better educated—appeared more willing to associate with those who had been mentally ill than did the “puritan” group, who tended to be in lower economic brackets and less well educated. Willingness to associate with former patients depended on the intimacy of the association. For example, 78 percent replied they would not object to having a discharged mental patient in their club but only 32 percent said they felt it would be possible to fall in love with someone who had been mentally ill. Thus, data from Prairie Town supported our assumption that people tend to fear and avoid the mentally ill. The questionnaire further indicated that degrees of proximity varied with the type of respondent and the type of situation in which the association occurred. Of course, it is likely that in an effort to appear enlightened and tolerant, some respondents expressed greater willingness to associate with the mentally ill than they really felt.

Answers to the questions on responsibility also showed wide variation, but this was not related to social and economic differences. Rather, it depended on one’s notions as to the cause of mental illness. Those who believed that the causes of mental illness were primarily biological did not feel so responsible for the mentally ill as, for example, those who believed mental illness was mainly due to social and economic factors.

The interview schedule was administered to a sample of 100 adults, as already mentioned. Most of the questions were “open-ended,” permitting people to express their opinions quite freely. The interview material was typed in detail and stored

in Prairie City until it could be analyzed at leisure after the educational campaign ended in Prairie Town. When the results of the interviews were finally processed, this paramount impression emerged: popular thinking about mental illness appeared confused and inconsistent. Conceptions of the nature, cause, and treatment of mental illness seemed hazy and frequently contradictory. In general, the people tended to regard as "normal" a much wider range of behavior than psychiatrists would. Behavior that would seem clearly pathological to a psychiatrist would be dismissed by many respondents as "just a quirk" or by saying "he'll get over it" or "it takes all kinds to make a world."

As part of the interview, six "cases" were briefly described, each typifying a different form of mental illness according to psychiatry. These were presented as specific individuals. Only their behavior was given; no psychiatric labels were attached. Most of those interviewed agreed that the description intended to exemplify a paranoid schizophrenic was indeed that of a person who was "mentally ill." But for each of the other five cases, a majority of the people denied that the person described was mentally ill. Between 65 and 76 percent rendered the judgment "not mentally ill" in the cases representing respectively a chronic alcoholic, a woman with simple schizophrenia, and a man diagnosed clinically as "a depressive with underlying suicidal tendencies," although more than half the respondents agreed there was "something wrong" in each of these three instances. Only 4 percent thought the case of a delinquent boy reflected "mental illness," and many found the behavior of a compulsive girl with phobic features praiseworthy because of her excessive care concerning details.

The question "What is mental illness?" drew a wide variety of answers. Most respondents tended to make a sharp distinction between insanity or mental illness (considered serious and virtually incurable) on the one hand, and "nervous" disorders (less serious and amenable to treatment) on the other. However, in citing symptoms, they tended to attribute the same symptoms to both types. Asked to characterize mental illness, they cited a wide range of attributes: unpredictability, violence, irrational behavior, anxiety states, withdrawal, depression, and others. Of these, "unpredictability" was most frequently cited.

However, it appeared that the single most important criterion for adjudging a person sane or insane was whether or not he had been institutionalized. A mentally ill person was someone whom doctors had acclaimed mentally ill by placing him in a mental hospital. Thus, it can be inferred that the same behavior that was judged "normal" in a nonhospitalized person was judged "abnormal" in one who had been hospitalized.

Notions of the cause of mental illness appeared to be unsystematic and often mutually contradictory. Many factors were cited as capable of causing mental illness, ranging from purely biological factors to bad social conditions. In general, the human organism was visualized as a machine in very delicate balance, easily upset or put out of order. A small number of people attributed mental illness to moral dereliction, a punishment for failure to live a clean and moral life.

Conceptions of cure of mental illness were related to ideas of its cause. Those who saw biological factors as causing mental illness tended to believe that it could be readily cured by a doctor or a nerve specialist, who would fix up the "nerves" that had gone wrong. Those espousing moral causality felt that mental illness could be cured by returning to correct moral behavior and seeking salvation.

Almost everyone expressed great confidence in the effectiveness of mental hospitals as agencies of cure. If the machinery of the body was easily thrown out of kilter, it could as easily be righted. This picture of mental illness as something readily cured by doctors and hospitals appeared to contradict the conception of mental illness as essentially incurable. Similarly, the picture of mental hospitals as highly effective agencies of cure appeared inconsistent with the tendency to class as "mentally ill" only those who had been hospitalized.

Attitudes toward the mentally ill expressed during the interview were similar to those revealed by the paper-and-pencil questionnaire. Half of those interviewed felt that insane people were dangerous to be near. More than two-thirds claimed that while they personally would not feel differently toward someone who had been mentally ill, others would; it is likely that the attitude attributed to others was really their own.

Why the Hostility?

It will be recalled that an important motive for trying to change popular attitudes toward mental disease was our conviction that misconceptions about the cause and nature of mental illness were harmful to discharged patients, tending to drive them back to the hospital. It will be recalled that our educational program aimed to replace erroneous conceptions with three basic ideas: the range of "normal" behavior is wider than is generally realized; abnormal behavior does not just happen but is caused and therefore subject to change; abnormality and normality are not two separate and unrelated states, but rather differing manifestations of the same kinds of behavior.

The results of our attitude questionnaires and interviews showed us that some of our educational efforts were misdirected. The "fit" between their set of ideas and ours appeared haphazard and unsystematic. Apparently the people of Prairie Town not only already believed that a wide range of behavior was "normal," but were willing to accept as normal an even wider range of behavior than were most psychiatrists. As to our next point, that disturbed behavior is "caused," the people of Prairie Town already knew this. They differed from medical personnel in that they imputed a different set of causes—a set more ramified and inclusive and yet less logically consistent than medical notions of etiology. It was our third idea—that there is a gradation rather than a sharp division between normality and abnormality—that diverged most strikingly from popular conceptions.

It was our hope that the net results of our program would be to make people more accepting of the mentally ill and more willing to act toward them as they did toward "normal" people. It was precisely this result that the people of Prairie Town seemed determined to prevent. Their ideas about mental illness and the mentally ill appeared inconsistent and often illogical when judged in terms of our ideas, but looked at in their own terms they were consistent, even reasonable and necessary. The whole set of ideas, beliefs, and attitudes about mental illness held by the people of Prairie Town was a response not to considerations of empirical truth, but rather to the needs of the community. For the community of Prairie Town, it was far less important to know the detached "truth" about mental illness than to have some workable way to handle the difficult problem of mental illness. A crucial element in their method of handling this problem was belief in a black-and-white difference between the sane and the insane, and the concomitant conviction that the mentally ill must be removed from the community. These popular ideas were diametrically opposed to those our educational program sought to teach. As we worked to determine the popular ideas and replace them with "correct" ideas, people became increasingly upset and angry. Why should this be so?

From the point of view of the people of Prairie Town rather than from a scientific or clinical standpoint, their ideas concerning the nature, cause, and treatment of mental illness formed a consistent pattern, one we can call the "pattern of denial and isolation." Many aspects of the behavior of the community became meaningful once we began to view them in the context of this pattern. Briefly, the pattern is as follows: People tend to deny the existence of abnormal behavior for as long a time as they possibly can. When behavior becomes so deviant that it can no longer be tolerated or construed as normal, people act to isolate the mentally ill person, both physically and conceptually.

The attitudes expressed in the questionnaires and interviews, as well as the observed behavior of the people of Prairie Town, testify to this pattern. Responses to the psychiatric cases in the interviews showed that the people tended to deny the existence of disturbed behavior, to "normalize" what was clinically mental illness. A very wide range of behavior was accepted as "normal." Having a wide and heterogeneous conception of the cause and nature of mental illness helps to maintain this acceptance. However, once a person is definitely categorized as "mentally ill," usually because he has been hospitalized, people's attitudes sharply reverse themselves. Instead of saying in effect, "He's just about like everyone else," people say, "He's very different from everyone else and must be separated from normal people." The attitude questionnaire showed that people wished to avoid close contact with the mentally ill. It also showed a considerable fear of disturbed persons, as we had anticipated, along with a tendency to be ashamed of that fear.

The feeling that mental hospitals are good places and will cure the mentally ill is connected with the desire to put out of one's mind all thoughts of a

mentally disturbed friend or relative. Once a person is placed in a mental hospital, he is "put away" both physically and from one's thoughts, and the picture of the mental hospital as a desirable place helps to assuage the guilt a person might feel at so isolating a friend or relative. Once a person is admitted to a hospital, he is virtually deserted by friends and relatives, as if contact were somehow contaminating and dangerous.

It is evident that this whole complex of beliefs and attitudes is a product of the community's attempt to solve a perplexing problem. At the core of this solution is the need of the community to separate itself from deviant people. The people themselves indicate that "unpredictability" of behavior is the basic reason they fear the mentally ill, but since most of the mentally ill are scarcely less predictable than anyone else, it is likely that people equate deviation from behavioral norms with unpredictability. The pattern of denial and isolation arises from the attempt on the part of the community to maintain its code of conduct and hence its own integrity by protecting itself from deviant behavior.

The reasoning runs like this: There are two main kinds of people—people like you and me, and the mentally ill—and there is a sharp line between them. When a person's quirks, odd habits, "different" behavior, funny actions are still reasonably close to those of most people, he belongs in the ranks of the sane. The community tries to keep him there by "denying" as long as possible that such behavior constitutes mental illness. But if the behavior of the disturbed person produces some conspicuous results—a breakdown, commitment to a psychiatric ward, an undeniable breach of the laws of society—the community then mobilizes to protect itself and its rules of conduct. It does so by suddenly branding the disturbing person "insane," a verdict carrying the sentence of banishment. He is now in a completely different category from "normal" people and must be treated differently. The community, in order to maintain the sanity and balance of its members, must dissociate itself from the now dangerous deviant.

It may now be understood why our educational efforts caused so much disturbance in Prairie Town. In our attempt to produce a more permissive climate for former mental patients, we conveyed the idea that they were pretty much like everyone else, and that there was no sharp line dividing the sane from the insane, but rather a continuous range of behavior. In stressing this idea we were hammering directly at the core of the community's own solution to the problem of the mentally ill. Our problem was not theirs. We were concerned with the cure of the mentally ill; the people of Prairie Town were concerned with the stability and solidarity of their own community. In striving to achieve our purpose, we violated theirs.

From our therapy-centered viewpoint it was evident that mental hospitals are not the best means for curing the mentally ill; the hospitalized patient is maintained in an artificial situation isolated from the beneficial influence of normal social intercourse. In trying to educate the community to this point of view we challenged a basic part of their solution to the problem of mental illness. The community

“solves” this problem by putting the mentally ill in a class apart and keeping them in isolation, but underneath it is uncomfortable about the solution. Doubts as to whether this is really the right way come to the surface from time to time. People cope with these doubts by reassuring themselves and one another that the mental hospital really is the best place for anyone mentally ill, that people are cured there, and that their hospitalized friend or relative is really being helped much more than if he remained in the community. We have noted the almost pathetic eagerness of the relatives of the hospitalized mental patients to assure themselves that this was a good hospital, or at least better than most others.

By informing the people that many mental hospitals were in fact overcrowded, inadequately staffed, and maltherapeutic, we were destroying the device people used to assuage their guilt over having exiled their relatives. If people accept our assertion that mental hospitals were undesirable or even harmful, they would have to face their own inner feelings of guilt and shame, feelings that had been kept in check by their motivated evaluation of the mental hospital as a “good” place.

In short, Prairie Town’s pattern of beliefs and attitudes toward mental illness was not merely a patchwork of half-truths, fallacies, and inconsistencies, as appeared from a first inspection of the interview data; it played an important part in preserving the well-being of the community and the peace of mind and self-esteem of the average individual. When they sensed that our educational program was a concerted attempt to weaken and dislodge these protective beliefs, the people of Prairie Town became disturbed and anxious and warned us indirectly to soften our message and relax our efforts. When we persisted, their anxiety went over into active hostility. To protect itself, the community mobilized to eject the disturbing forces.

Implications

We all base our lives on certain cultural assumptions about the nature of disease, the proper way to raise crops, what are wholesome and unwholesome foods, and a myriad of other attitudes and beliefs. It is reasonable to suppose that these are organized into a workable interrelated pattern. Thus, any sudden onslaught on a particular set of beliefs, whether they concern diet or mental illness, may cause considerable dislocation in this whole system. However, attempts to change beliefs and attitudes will probably go on and we can only hope that this will be done more and more skillfully so that the process will become less uncomfortable both for the educator and for the public. What can our experiences in Prairie Town teach us about planning and carrying out similar programs in the future?

The Program in Retrospect

Reviewing the total program, there are a few things we are glad that we did as we did. Among these was our gradual and unobtrusive entry into the

community. We feel sure that this town could not be taken by a frontal assault. The fact that we offered to aid the various organizations in planning their programs facilitated cooperation. Establishing contact with and explaining our program to key figures in these organizations before our publicity campaign began helped in gaining their cooperation. We were wise to have dissociated ourselves from the government and any specific organization already in the town and to have avoided identification with any particular group or person until we could gauge how well they were accepted by their fellow citizens.

There are several factors which we might have anticipated, but did not. For one thing, we had no moral purpose in our stated aims. If we had had such a purpose, greater cooperation would probably have been forthcoming from the various religious groups. In addition, we had no real program of action. That is, we did not, for instance, realize until too late that there was a considerable force in the community that favored building a common recreation center. To have allied ourselves with such a cause early would perhaps would have given more meaning to our campaign. Furthermore, although we had anticipated some anxiety, we were perhaps not sufficiently zealous enough in reading those signals presented to us. Further, we had no suitable program, if such is possible, for dealing with this anxiety as it arose.

Other conditions could have been made evident only by more thorough advance investigation of the community. Had such a study been made we would have been aware, for instance, that the town was divided rather sharply into a low-educational group, which included the Metis minority, and a middle- and upper-educational group. We would have learned in advance that there were two segments within the educated group—"joiners," who made up the membership of most of the town's 70 organizations, and those who admired the puritan virtues and stood apart from most organizations other than the Protestant churches. This knowledge would have alerted us to the difficulty of trying to reach the whole population through these 70 organizations.

Moreover, we would have become aware of the sharp Protestant-Catholic schism in the town, which had been made more intense by the militant activity of a recently appointed priest. We would have found that the dominant Protestant minister had accepted a call to a city church and would probably not be much interested in innovations, and we would have been dubious of the possibility of working simultaneously with Catholics and Protestants. We might have concentrated on working through the Catholic Church to reach the low-education group while attempting to reach the other educational groups through secular organizations.

An advance community survey would have revealed that the technically educated workers in the government agricultural stations were a group separated from the rest of the community. The town regarded them with mixed feelings,

and while they could have damaged the program if they felt slighted, close identification with them could alienate other sectors of the community.

Other factors could not have been anticipated, although better knowledge of the community might have made them easier to cope with. One such unforeseen event involved the local priest. A very cordial relationship was initially established, and there was every likelihood of getting his cooperation in working with the Catholic portion of the community. However, just about the time our program began, a psychiatrist in Montreal made a radio speech in which he implied that religion was detrimental to mental health, and about the same time a West Coast mental health group brought out a pamphlet on masturbation, describing it as a normal and natural part of childhood. These two claims drew a sharp official rebuke to mental health organizations by a high church official, and the cooperation of the local priest disappeared almost overnight.

Similarly, one cannot anticipate the weather. An unusually wet autumn delayed harvesting operations and kept many resident farmers out of town almost a month later than was usual, while a warm dry spring had a similar detrimental effect on the terminal part of our program.

Limits for Health Education

Our experience in Prairie Town may be summarized under four general points. Each of these poses questions for the health educator. First, we found, as others have, that mass media were less effective than group contacts. But in working with groups, we faced the problem that organized groups in Prairie Town were composed of and controlled by a relatively small portion of the total community. What are the techniques by which we can reach the less-educated groups in these communities? How does one present complicated ideas to people who are relatively *unable to integrate them into their own experience?*

Second, it became evident that people were motivated toward learning only when they felt that the material applied to them personally. How are people to be motivated toward learning without "scare" techniques ("one person in 20 will spend time in a mental hospital"), since scare techniques inevitably produce undesirable side effects? This point would seem obvious from the upsurge of phobias and anxiety states centering around cancer and syphilis after educational programs of this type have been attempted.

Third, we can speculate as to whether a tangible action program or a treatment clinic introduced in the program might have produced more motivation to learn new attitudes and helped to reduce anxiety. If such extension of a project is sometimes advantageous and sometimes detrimental, are there criteria for judging when such extension is advisable and when it is not? When does extension of a program make it more vulnerable by providing more areas in which to make mistakes?

Finally, our experiences in Prairie Town made it abundantly clear that any energetic attempt to change attitudes and beliefs will produce anxiety. To some extent this is true even for areas of apparently minor importance, such as attitudes toward the use of powdered eggs or a new kind of seed corn. But this phenomenon becomes increasingly evident as one begins to deal with beliefs and attitudes closer to the core of a people's culture. The pattern of beliefs surrounding mental illness is certainly close to this core because it touches the very network of interpersonal relations that binds a community together. Any attempts to change existing attitudes in so vital an area must be approached with caution. There seems to be little doubt that anxiety will be aroused no matter how carefully one plans or how cautiously he proceeds. Would virtually the same results have occurred had we based our program in Prairie Town on better knowledge of the community and more sophisticated assumptions, avoiding the various practical and organizational pitfalls just cited and spreading our educational program over years rather than months?

This poses questions for the worker attempting mental health education. Can the anxiety associated with efforts to touch this area be lessened by moving more slowly, working less intensively, using different techniques, or confining such education to optimally receptive communities? Can a set of techniques be developed for handling this anxiety? Can it be controlled and made to facilitate rather than disrupt the learning process? Is it wise to attempt such a program at all? If "erroneous" beliefs about mental illness in fact fill a critical social need, should the effort be made to change them? Will the benefits accruing to the mentally ill outweigh the possible "cost" to the community in augmented insecurity about its own sanity and standards? If misconceptions about the mentally ill serve to reaffirm the solidarity of the sane, how can health workers best avert the risk of disrupting this solidarity? The case of Prairie Town has not answered these questions nor could it answer them, but it has shown clearly that they must be asked.

Summary

A six-month educational program designed to alter popular attitudes toward the mentally ill was carried out in a small Canadian prairie town. Questionnaires and standard interviews were administered before and after the educational program to measure its effects. The tests showed no appreciable change in beliefs about mental illness or attitudes toward the mentally ill as a result of the program. Interviews and other data pointed to the existence of a community "pattern of denial and isolation" as a method for dealing with the threat of mental illness: the existence of abnormal behavior is denied as long as possible; when denial is no longer feasible, the degree of abnormality is exaggerated and the ill person is isolated socially and conceptually, as well as physically. Although malfunctioning in reference to the rehabilitation of the mentally ill, this pattern

appeared functional in reference to the maintenance of community solidarity. Efforts to change parts of this pattern by education produced anxiety and hostility. The Prairie Town experience indicates that mental health educators must carefully take into account the social function of beliefs about mental illness, anticipate the occurrence of anxiety, and prepare themselves for difficulty and slow success.

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