CONCEPTIONS AND MANAGEMENT OF MENTAL ILLNESS IN OUTPORT NEWFOUNDLAND

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by

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ABSTRACT

The theoretical background for this exploratory study is derived from the societal reaction school of deviance theory. It is an examination, through the use of both interview and participant observation data, of the conceptions and management of mental illness in the isolated "outport" settlements of coastal Newfoundland. The study discusses the effect, on both of these phenomena, of differential access to medical and other professional agents, and through this analysis, challenges the traditional interpretations of psychiatric hospital admission rates.

The outport conception of mental illness is examined in the light of community culture and interactive structure, in an effort to illustrate that lay conceptions of mental illness entail judgements of the social, rather than psychiatric, nature of behavior.

The process of coming to be defined as mentally ill by fellow community members is seen as the function of a number of social contingencies. The definitional process is outlined in some detail in an attempt to integrate the relevant contingent factors. Hypotheses are offered about the nature of the lay conceptions of mental illness and the validity of the research focus is briefly evaluated.

PREFACE

Most discussions of mental illness have centered on the interpretations made of behavior by medical and psychiatric professionals. Little systematic evaluation of the reaction to disordered behavior by non-professionals has been made. Yet some writers have argued that it is exactly these laymen's conceptions of behavior which will determine what individuals come to the attention of doctors and psychiatrists.

This study was designed to explore the conceptions of mental illness held within a particular type of society, the coastal fishing communities of Newfoundland, in an effort to delineate the societal reaction of non-professionals to that deviant behavior which might be considered to be mental illness by professionals. Several dimensions of this societal reaction are elucidated in the pages to follow.

Dr. R. A. Stebbins supervised the planning, execution and reporting of this research and I am extremely grateful for his friendly support and guidance throughout. There is hardly a member of the Department of Sociology and Anthropology, Memorial University of Newfoundland, to whom I do not owe gratitude, both for assistance in the research project and for creating a stimulating and thoroughly enjoyable educational experience. My thanks to the university's Institute of Social and Economic Research for generous financial support of the research project and to the department for funding the data analysis.

My warmest sentiments must be reserved for the people of the research setting. Their friendship and co-operation not only made the

research possible, but also provided me with an extremely pleasurable period in my life. My greatest regret is that the requirements of social scientific writing prevent me from reflecting the warmth and beauty of their lives.

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Damn it, Harding, I didn't mean it like that. You ain't crazy like that. I mean - hell, I been surprised how sane you guys all are. As near as I can tell, you're not any crazier than the average asshole or the street. . . .

Ah yes, the asshole on the street.

But not, you know, crazy like the movies paint crazy people. You're just hung up and - kind of - .

(Kesey, 1962)

CHAPTER I

INTRODUCTION: CONCEPTUAL FRAMEWORK

Traditionally, theory in the field of social deviation has been derived directly from larger bodies of sociological theory (often referred to as "grand" theory) having to do with the functioning of large scale social systems, (Merton, 1957; Parsons, 1951). These macro-views of deviance assume that all cultural systems have rules which prescribed the behavior expected of actors in various roles and social situations and that these rules or norms are commonly understood by all members of the particular society. Explicit in this view of norms is the understanding that there are appropriate and commonly held patterns of reaction or sanctions for the violation of each norm. The sanctions directed at rule breakers were seen as having functions for the successful operation of a particular society, such as protection of conforming members, correcting dis-equilibrium in reciprocal relationships, and publically emphasizing the boundaries of acceptable behavior, (Erikson, 1962). Deviance was seen as a characteristic inherent in a certain kind of behavior.

The causes of deviant acts were conceptualized in a variety of ways, such as a disjunction between ends and means (Merton, 1957), contradictory sanctions (Parsons, 1951), ineffectiveness of sanctions (Durkhiem, 1897), or relative deprivation (Cohen, 1955). The principle that under-lay all these formulations was the assumption of social rather than individual pathology - that deviance was created by the social system and that deviants were the unfortunate victims of pernicious social processes.

This attitude led to research and theoretical interests that explained the different rates of deviance amongst societies and social groups as a function of the pathological elements of the particular social system, resulting in a concern with the social characteristics of the deviant acts and actors.

With the rapid growth in the past two decades, of sociological interest in micro-social phenomena and its consequent emphasis on interactive processes, theorists have become increasingly dissatisfied with the previous formulations of deviance theory. Unlike their predecessors, they note that deviance of great potential danger to the effective functioning of a society, such as corporate crime (Sutherland, 1949) is lightly and sporadically sanctioned, while other types of deviance of little danger to the social system, such as homosexuality, is reacted to quite strongly. They also call attention to the marked differences between social groups in the enforcement of norms supposedly commonly held within the society. With the growing awareness that the application of sanctions to deviant behavior is often mitigated by social contingencies such as social class, age, or race, they shifted the emphasis, both in theory and research, from the nature of deviant acts and actors to the quality of the societal reaction to these individuals and events. Deviance has come to be seen as a property conferred on behavior rather than a characteristic inherent in it. Becker (1964: 9), presented perhaps the most concise statement of the societal reaction perspective:

> Social groups create deviance by making the rules whose infraction constitutes deviance, and by applying these rules to particular people and labelling them as outsiders. From this point of view, deviance is not a quality of the act the person commits but rather a consequence of the application, by others, of rules and sanctions to an offender. The deviant is one to whom that label has successfully been applied: deviant behavior is behavior that people so label.

The many theorists who have adopted the societal reaction perspective (Lemert, 1951; Kitsuse, 1962; Becker, 1964; Lofland, 1969; Stebbins, 1971) have shown a close link with the body of theory that has some to be known as symbolic interactionism, derived from the social psychology of Cooley (1922) and Mead (Strauss, 1956). Symbolic interactionism has provided the societal reactionists with some of their most valuable conceptual tools and research foci. Paramount amongst these has been the formulation of response to deviance as an interactive rather than a reactive process. The idea of a deviant career and its association with the self-concept engendered by the reaction of significant others to the deviant has greatly advanced our understanding of recidivism among deviants. The affect of being identified as a deviant is seen as giving the individual a master status or label which leads other people to impute to him characteristics, usually negative, not directly associated with his initial and subsequent deviant act (i.e. a sexual offender will be thought to be an unreliable employee and perhaps even an income tax cheater). This negative imputation or stereotype is thought to be incorporated in the self-concept.

The preoccupation of the societal reaction theorists with the influence of the deviant label in creating a commitment to a deviant career and thus a liklihood of further deviance has resulted in a

tendency to dismiss as relatively unimportant the cause of the inital act, which leads to being labelled (Lofland, 1969 and Lemert, 1951 have made attempts). This has influenced research efforts in the direction of social histories and the process of labelling and away from the social correlates of deviant acts and actors. This bias is understandable if we accept the premise that social deviance is behavior that has been so labelled by the community and that labelled and un-labelled deviant acts have the same causal basis, in other words, the crucial contingency for the deviant is the attachment of the label.

Kitsuse, summing up his research on homosexuals, concluded that not only are the processes by which persons come to be known as homosexuals contingent upon the interpretations placed on their behavior by others, but also the treatment they receive varies widely amongst members of various sub-cultural groups. He states (1962 : 256) that "a sociological theory of deviance must explicitly take into account the variety and range of conceptions held within the society concerning any form of behavior."

The societal reaction perspective and particularly the emphasis on conceptions of what actually constitutes deviant behavior is particularly applicable to mental illness. All theorists who write about social deviance tend to use various types of deviant behavior to illustrate their points (crime, homosexuality, alcoholism, etc.) and the types subsumed under the general term tend to vary with individual theorists. For example, not all writers include physical handicaps or facial disfigurement as do Goffman (1963), and Davis (1961). However, one of the types most generally

accepted as appropriately discussed under the rubric of social deviance is mental illness.

If we divide the social world of reactors to deviance into professionals - those offically designated by society to apply labels and sanctions to deviants - and laymen - those not so officially designated - we find that professionals consistently have a formalized set of criteria for deciding the deviant or non-deviant status of an act, and that this code, to varying degrees, is common knowledge amongst laymen. For example, the police act upon the prescriptions of the criminal code, and what constitutes a crime is fairly well known amongst laymen. In the field of psychiatry (those professionals charged with defining what types of behavior constitutes mental illness) there is apparently much disagreement. Several writers have commented on the vagueness of diagnostic categories (Goffman, 1961; Scheff, 1966; Szas, 1961) and their inherent contradictions. That laymen do not even come near sharing the professional definitions of what constitutes mental illness is amply illustrated by past and present research, to be discussed later in this report. Moreover, psychiatrists have amply documented the differing rates of diagnosed cases amongst different cultures and social groups as well as the high rates of undetected cases (using professional criteria) and variation in these rates (Eaton and Weil, 1955; Hollingshead and Redlich, 1958).

Thus it would appear that the definition of what constitutes mental illness is vague, conjectural and unevenly applied. It seems that an individual's being labelled as mentally ill is contingent upon the nature of the societal reaction to his behavior and that the phenomenon

of mental illness would benefit from analysis under the societal reaction framework. This perspective has been adopted by writers such as Szas (1961) and Goffman (1961) who have neatly paraphrased the societal reaction viewpoint by asserting that the mentally ill are those individuals who are treated for mental illness.

Other writers have made significant progress in applying the societal reaction perspective to mental illness and thus showing its validity as a conceptual tool. Scheff (1966) characterized mental illness as rule-breaking behavior to which no other deviant label can be attached - residual deviance. Sampson et al (1962) and Mechanic (1962) have traced many of the processes leading to an individual's coming to be defined as mentally ill. Goffman (1961) has elucidated the interactive process and the stages of the career of the mental patient. Nunnally (1961) has given us excellent data on the imputative aspects of the label "mentally ill". Lemert (1962) has gone as far as to explain paranoia as a function of the societal reaction.

A theme common to much of the major writing in the field (now of sufficient depth to be known as the sociology of mental illness amoungst its adherents) has been the strong tendency by the official medical-psychiatric definers to <u>assume</u> illness exists. Studies by Scheff (1964), Mechanic (1962) and others of official commitment hearing (the process by which a person believed to be mentally ill is legally incarcerated in an institution) show the presumption of the individula's illness by the professionals, resulting in cursory examinations and a decision to commit in almost all cases. Mechanic noted that in the course of his

three months study in two California mental hospitals, none of the individuals who voluntarily presented themselves for consultation were told that they did not require treatment. This theme has been supported in discussion by Goffman (1961) who stated that to be under psychiatric treatment is evidence, per se, of mental illness.

Scheff (1966) has provided the fullest treatment of the presumption of pathology by professionals by attempting to explain it through the nature of medical decision-making. Arguing that behavioral pathology is thought of by physicians and psychiatrists in terms of the medical or disease model of physical pathology, he believes that professionals opt for treatment rather than non-treatment whenever they are unsure if a pathology is present. In other words, they believe it better to treat a disorder that does not exist than not to treat one that does exist. Although this is a reasonable and expected orientation to physical disease, labelling someone physically ill has far more benign implications than labelling them mentally ill - at least in terms of self-concept and societal reaction.

Despite some opinions to the contrary (e.g. Gove, 1970), the weight of discussion and research seems to favour heavily the position that professional diagnosis of mental illness as an almost automatic acceptance of pathology existing in most individuals presented for examination. Naturally, this position focuses attention on the processes which initially brings individuals to the attention of their professional "treaters". The literature is rich in research which illustrates the importance of the processes by which the family or other primary groups come to define a

member as mentally ill and bring him into contact with professional agents (Lemert, 1962; Eaton and Weil, 1955 Sampson et al, 1962; Goffman, 1961; Hammer, 1963; Clausen and Yarrow, 1955). It seems that since physicians usually presume pathology in most individuals presented to them for consultation, the crucial defining decision is made by the primary group members, a decision that sends these individuals to the professional forassessment and confirmation or refutation of suspicions that their behavior is pathological. This focuses attention on the conceptions or lay-definitions of mental illness held by the non-professional members of the community, as Mechanic (1962: 70) puts it:

> ...the basic decision about illness usually occurs prior to the patient's admission to the hospital and this decision is more or less made by non-professional members of the community. It therefore becomes a matter of considerable interest to understand how these non-professional members of the community define mental illness.

Mechanic has stressed the importance of lay conceptions of mental illness in much the same manner as Kitsuse (1962), in the passage cited earlier, stressed the importance of lay definitions for social deviance in general. This concern brings us to the main focus of the research to be reported in the following pages: What are the conceptions held of, the patterns of reacting to, the attitudes towards, and the relevant contingencies bearing on the definitions of mental illness in a distinct population or cultural group? Some survey research has already been carried out, and is discussed in Chapter III, on some of these problems and on others to be raised in the discussion to follow. However, these earlier studies have two major failings. Their results have never been

reported in any comprehensive fashion and sometimes were not reported at all. Also, the sample populations have been either so large or so diverse in physical and social location that the researchers were unable to see the significance for them of the underlying social and cultural systems in which the interview respondents lived. That is, they did not support their interview data with participant observation or ethnographic data. This linking has been attempted in the present study. Another contribution of this study, although it would be partisan to consider it a failing of the previous works, is the use, as fully as possible, of the societal reaction framework. Thus, the data presented here are, to some degree a test of its validity as a conceptual tool in understanding the process of coming to be defined as mentally ill.

Chapter II deals with the philosophy underlying the research methodology itself and the analysis of both survey and participant observation data. I also attempt to describe the research setting, a relatively remote group of communities in coastal Newfoundland, without digressing into a comprehensive ethnography, which is beyond the scope of this report.

Chapter III presents the results of the formal interview phase of the fieldwork. The implications of the data as well as the effects of certain selected social parameters are discussed. There is a discussion and comparison of previous findings, whenever possible.

Chapter IV deals with a major factor that influences variation in conceptions and management of mental illness: namely, the accessibility of professional referral or treatment agents. The implications of the

findings in this area are discussed for both the distribution of professional resources and the theory of social deviance.

Chapter V contrasts interview and participant observation data in a discussion of various forms of identity management evolved from the interactive process between the mentally ill and their "reactors", both lay and professional.

Chapter VI attempts to link various phenomena discussed in the previous sections with participant observation data concerning social deviants in the community in general and with the functioning of the community and smaller groups as distinct social systems. I try to make a case for the social, rather than pathological origins of coming to be known as mentally ill.

Chapter VII attempts to draw the foregoing data and discussion of the study into a set of concluding statements and to briefly assess the validity of the societal reaction perspective.

CHAPTER II

METHODOLOGY AND SETTING

The reader accustomed to the more traditional, formal style of sociological research report might have been struck by the conspicious absence, in the previous chapter, of carefully delineated hypotheses - logically deduced from a body of theory and offered for verification or rejection in the study under discussion. This lack, rather than being an oversight, is dictated by the philosophy underlying the research methodology and in turn by the exploratory nature of the research itself.

The previous research dealing with conceptions of mental illness (discussed in Chapter III) is scarce, sporadic, and poorly reported. In addition, previous studies deal mainly with urban, North American populations, which have ready access to a wide variety of professional treatment and social control facilities. Although the literature on Newfoundland coastal villages (termed "outports" in local idiom) is fairly rich and ever-growing, most work has been done by anthropologists and reflects their holistic ethnographic approach. Besides their traditional interest in such aspects as kinship patterns and economic strategies, some of the anthropologists work has dealt with interpersonal relations and other social psychological questions, both within and apart from the traditional concerns. However, both bodies of knowledge are insufficient to allow us to generate hypotheses about how outporters conceive of and deal with mental illness.

It appears premature, if not impossible, to generate hypotheses from available theoretical and empirical resources and then attempt to test them in a setting known to the researcher only through anthropological literature and hearsay. Rather, it seems that the best approach is to attempt to generate theory - that is, "grounded theory" - from data. This scheme, as Glaser and Straus (1967) point out, is not new; it is basically the approach of such sociological pioneers as Weber and Durkheim. It merely seems to have gone out of style with the development of quantitative research methods and sociology's pre-occupation with its status as a science, both dominant themes of the past three decades (symbolic of this is Merton's (1957) relegation of grounded theory to the status of "serendipity").

Glaser and Straus (1967) have resurrected grounded theory to its proper place of respect amongst sociologists by their painstaking elucidation of the process. The advantages they see in this approach are especially pertinent to the type of research attempted in this study. Any theory derived from data can be sure of "fitting" - any categories derived must be readily (not forcibly) applicable to and indicated by the data under study - and of "working" - being meaningfully relevant to, and able to explain the behavior under study. As categories are derived, continually modified, and finally validated, so theory emerges, giving "on the spot" direction to the research in process in terms of further foci and sampling. Foci are more flexible in that the researcher is not narrowly centered on data relevant only to the testing of a hypothesis. New theory is not always a goal in the "grounded" approach; established theories

may be further supported or modified. New theory will only arise when existing frameworks are inadequate to explain the data.

Theory generated from data raises to a new level of significance the interaction of various types of observation, both quantitative and qualitative, as well as allowing greater freedom in deriving categories from quantitative data alone. In particular, this study utilizes survey interview as well as participant-observation data. Discussing the value to the researcher of this approach, Glaser and Straus remark (1967: 225):

> ... he feels the worth of his final analysis.... what is more, if he has participated in the social life of his subject, then he has been living by his analyses, testing them not only by observation and interview but by daily living.

(1967: 226):

> But a first hand immersion in a sphere of life and action - a social world - different from ones own yields important dividends. The field worker who has observed closely in this social world has had, in a profound sense, to live there. He has been sufficiently immersed in this world to know it and at the same time has retained enough detachment to think theoretically about what he has seen and lived through.

Utilization of both quantitative interview data and qualitative observational data in this research has provided insights, grounds for generalizations, indications of new directions to take, and, occasionally, puzzling contradictions. Hopefully the value of these data and that of the grounded theory approach in general is illustrated by the following discussion.

Before proceeding to a more concrete description of the actual data gathering techniques, perhaps it would be wise to qualify some of the preceeding discussion in anticipation of possible confusion on the

part of the reader. First of all, the elaboration of the societal reaction perspective, especially as it pertains to mental illness, contained in the previous chapter, may seem at odds with the expressed intention of not testing an established theory but rather of generating theory from data. The main purpose of the first chapter was to provide a broad framework from which to emphasize the importance of lay-conceptions of mental illness. The test of the validity of the societal reaction perspective is an auxiliary function of this analysis, and most energies will be channeled in other direction. Specifically, I will be developing hypotheses about lay-conceptions of mental illness as one aspect of the societal reaction to such behavior. In other words, societal reaction is the focus of the study, rather than the object of testing by hypothesis.

Secondly, it cannot be merely said that societal reaction to mental illness is the object of the study. Obviously, the planning of field research in an unfamiliar area, even from the grounded theory perspective, requires a more explicit idea of just what one is looking for in the way of data. This problem can be solved, short of deducing testable hypotheses, by delineating areas of concern which later in the actual field work will be amplified, re-conceptualized, diversified, and perhaps even dropped, according to the day by day research experiences. The major concerns which dominated the planning of this study were such questions as: What are the conceptions held by the sample population of what actually constitutes mental illness behavior and its causes? What other kinds of behavior do they regard as socially deviant? What are the patterns of reacting to mental illness behavior compared with other types

of behavior? Do these patterns of reacting include lay and professional treatment orientations? Does the community tolerate individuals that are commonly thought to be mentally ill? What special roles, if any do these individuals occupy? What patterns of interaction characterize relations with professional "treating" and social control agents? What effects, if any, do differing degrees of isolation from professional facilities have on the relationships and other contingencies relevant to the mentally ill? What is the pattern of coming to be defined as mentally ill?

A final comment should be made about the lack, in previous discussion, of a definition of the term "mental illness". Implicit in the societal reaction perspective and the research concerns outlined about is the tenet that I will allow the population studies to define mental illness for me. The analysis to follow teases out this definition, so that I am able to discuss it in concluding statements, as fits the philosophy of the research approach.

Data - Gathering

The formal interview was a slight modification of that developed by Shirley Star for a massive survey of attitudes towards mental illness. The survey, conducted in 1950 by the National Opinion Research Center, involved interviews with 3500 respondents in the U.S. Unfortunately, the results of the survey were never published in any comprehensive form and the only record of the findings are sporadic references in several papers read at professional meetings by Star (1952, 1955). Other researchers have used the interview format in full or in part and their efforts will

be discussed along with the results of the current study.

The interview schedule (Appendix I) has several features particularly relevant to this study. Firstly, the questions are open-ended, rather than structured. This enables the researcher to derive categories of responses from the data and to integrate these categories with his knowledge of the local situation, such as relating categories of referrals to professional agents to his knowledge of the availability of these resources.

A second advantage is that this interview schedule does not merely ask respondents what they think about "mental illness", thus giving no insight into what kinds of behavior they are subsuming under that label. The interview asks initially what are the types of behavior the individual associates with the term "mental illness". Then it presents a number of descriptions of behavior or profiles, asking detailed questions about each profile in turn, such as "is this person mentally ill?" and "what should be done about this person?". The profiles were constructed for Star by psychiatrists and each represents a particular type, in the psychiatrist's view, of mental illness. They include the psychiatric diagnostic categories of a paranoid schizophrenic, simple schizophrenic, anxiety neurotic, alcoholic, compulsive-phobic personality, and a childhood behavior disorder.

The interview also asks certain general questions about people who have "nervous conditions" and people who are "insane", a useful distinction for the study and one which is discussed in Chapter V.

Forty-eight interviews were conducted, twelve in each of four different communities, and none more than eighty miles from each other.

The interviewers were selected randomly from a list of households published annually by the Post Office Department. Although a census tract or voters list would have provided a list of all adults and thus a more representative sample, none were available which were sufficiently current.

Each prospective interview was sent a letter announcing the researcher's intention of visiting within a few weeks, the purpose of the study in general terms, and requesting their co-operation. Only one individual refused to be interviewed. In several cases the person sought was either deceased or unavailible for some time, in which case the spouse was interviewed. Interviews were carried out in a leisurely fashion, usually leaving time for chatting afterward, which often provided additional valuable information in that these casual conversations usually centered on mental illness. While interviewing in the three communities other than the one used as a base, I made it a practice to board within the community rather than commuting daily as would have been possible in two cases. This was done in an effort to familiarize myself with and become familiar to the community, thus lessening the degree of fear and suspicion with which strangers are often regarded.

The interviews were divided amongst four communities because of the interest in the effect of differing degrees of isolation from professional agents and facilities. Two communities of roughly equal inaccessability, rather than one, were chosen to be compared with two other less isolated communities, to separate the effects of community culture from the effects of isolation.

A total of nineteen weeks were spent in the area, seventeen weeks

in the spring and summer of 1971 and two weeks in January 1972. When not interviewing in the other three communities (about three weeks were spent away) I lived in the fourth. Although I had never visited the area before, my father and his family had been natives of a nearby community. Despite the fact that the family had left the area over thirty years before, there were many individuals who remembered them well and even a few distant kin. This background proved valuable in that it lessened my "stranger" status while not closely identifying me with any existing group or faction that could limit my movements or acceptability to other groups.

I attempted to participate in all aspects of community life as fully as possible. From remarks made by community members, my obvious enjoyment of most of these activities seemed to hasten my acceptance as, if not a complete member, at least a "fellow traveller". After an initial stay in a boarding house, and when I believed my contacts were stable enough I rented a small house to live in, which enabled me to receive visitors and seemed to emphasize my commitment, if only temporary, to the community and its way of life.

Given the traditional cordiality and hospitality of the community (at least by urban standards), it was not difficult to make many contacts and move in many community circles. The concern of the study with mental illness and to a lesser degree, social deviance in general, directed my interests somewhat. After achieving some degree of acceptance, I gained at least partial access to the gossip networks and much of my most useful information along these lines came via this channel, which, as in most

settings, was largely concerned with the behavior of fellow social actors. Care was taken to not initiate these conversational themes and to only probe them if the situation warranted it. Although formal interviews in the home community were not conducted until the latter part of my residence there, a general idea of my interests gradually emerged among most of my contacts and they often volunteered opinions and even information in which they thought I would be interested. There seemed to be little resentment of my concern with mental illness, for reasons which are discussed later.

A somewhat more directed aspect of community study was a series of informal interviews conducted with professional agents such as doctors, clergymen, welfare officers and the local Royal Canadian Mounted Police. The professionals proved cooperative once my purpose and interests were known. Also, on several occasions, individuals spontaneously volunteered that they or close kin had received professional psychiatric treatment and expressed an interest in telling me of their experiences, a valuable source of information.

During the latter part of the summer, a local merchant who operated a "taxi" (a large van with passenger seats) left for a brief vacation on the mainland and asked me to assume his responsibilities regarding the transportation of the local doctor. This involved driving the doctor to his regularly scheduled clinics and emergency calls in nearby communities, as well as transporting emergency cases to the local hospital, fifty-six miles away. This experience was valuable in providing insights into the functioning of the local medical service and extensive contact with the doctor himself.

Before proceeding to a description of the research setting, it is appropriate to make several comments on the analysis and presentation of data that follow. First of all, in the analysis of the interview data, I use no statistical tests of significance. This position is dictated by several concerns about the relevance of these tests. As Labovitz has amply pointed out (1970; 1971), the tests themselves are suspect. To paraphrase his criticism of significance tests, they yield trivial results, are greatly affected by sample size, degrees of freedom and power efficiency, provide an inference to sample population only, are based on assumptions often impossible to meet and are beset by the impossibility of knowing the extent of Type II errors. A second concern is closely tied to the exploratory nature of the present study. As Glaser and Strauss argue (1967), statistical relevance does not necessarily mean theoretical relevance. They note (1967: 200) that "tests direct attention away from theoretically interesting relationships that are not of sufficient magnitude to be statistically significant."

That Labovitz and Glaser and Straus are not alone in their dissatisfaction with significance testing is evidenced by the large number of critical papers collected by Morrison and Henkel (1970). In the present study, with only forty-eight respondents divided into comparative groups of twenty-four, it would limit the generation of hypotheses to impose the arbitrary criterion of statistical significance. I will, instead, content myself with identifying trends in the data and illustrating their empirical significance.

Another concern centers on the presentation of participant

observation data of potential embarrassment to the individuals and community involved, given the focus of the study on behavior generally considered socially unacceptable. In addition to the traditional use of pseudonyms, I will give only that information about individuals and communities I consider theoretically necessary and anonymous.

The Outport Setting

Any effort to describe the cultural patterns of the coastal or outport settlements of Newfoundland short of a complete ethnography does injustice to this unique and fast-changing aspect of Canadian life. Since holistic ethnography is not the object of this study, a brief and over-simplified description of the research setting must suffice. The reader wishing more information on the extensive anthropological and sociological literature now available should see, for example, Faris (1966), Firestone (1967), Wadel (1969), DeWitt (1969), Chiaramonte (1971).

The historical tendency for immigrants to the island of Newfoundland to settle in small communities along the better than 6000 miles of coast is attributed to a number of factors (Iverson and Matthews, 1968) including fear of the British navy (many of the early settlers were either deserters from the navy or violaters of the ban against permanent settlement) and the distribution of fish and other scarce resources. The economy of the island, and particularly the outports, has always been and remains, based largely on exploitation of the rich fishing resources of the surrounding waters. Economic developments, starting in the 1920's

and greatly accelerated since Newfoundland became Canada's tenth province in 1949, has led to a decline in the number of outports. Industrialization in pulpwood, mining, construction, and large-scale trawler fishing has led to increasing centralization of the population in the larger towns and a consequent de-population and abandonment of many outports. This process has been greatly accelerated, since joining Canada, by a government sponsored plan to financially assist outporters to resettle in larger communities.

Although Canadianization and increasing modernization have brought to the outport residents the benefits of Canadian citizenship, many communities remain relatively isolated by mainland standards; they retain many of their traditional patterns of culture and strategies of exploiting an often harsh and forbidding environment. Kinship ties remain strong and the principle form of economic endeavour is still the inshore fishery, which is conducted from small boats and whose product, to a certain degree, is processed locally. However, at least in the area of the present study, signs of change are evident. The population is visibly lacking in young and middle-aged adults, a result of migration to larger centers or the mainland in search of more stable economic opportunities than those offered by the inshore fishery. Even those individuals who choose to remain in their outport home are forced to leave their family behind for much of the year to work on the trawler fleets of larger centers or on the mainland. The communities are heavily subsidized by a variety of transfer payments such as social assistance, old age pension, and veteran's allowance.

On a more positive note, the area studied has been serviced for six years with electricity and most homes have television and radio. A local road system has been built up over the past ten years and now connects most communities with each other. All communities have indoor water and sewer service and telephone service. The variety of consumer goods available from local merchants is ever increasing, and the influx of cash since Confederation has freed most people from dependence on the merchant's credit-for-fish exchange system. Two high schools now serve the area, moreover, a number of local students have gone on to attend university in the capital city of St. John's.

Social interaction is characterized by almost ritual cordiality, hospitality, and reciprocity. Strangers are treated with respect, courtesy, and underlying suspicion, as is discussed later. Social occasions, or "times", are held frequently and are well attended, with people often travelling from neighbouring communities to participate. The church plays a significant role in this social life, but organized religion has declined in its overall influence in community life, according to local informants.

The area studied was chosen, not only becuase of the kinship ties of the researcher, but also becuase it remains one of the more isolated of the province. Thus, it has not felt, as fully, urban and mainland influences as some of the communities nearer the capital. It comprises ten communities (Figure 1) ranged on one side of one of the major bays by which Newfoundlanders geographically identify themselves. The physical profile of the area is rocky and almost mountainous; the land is too barren to support

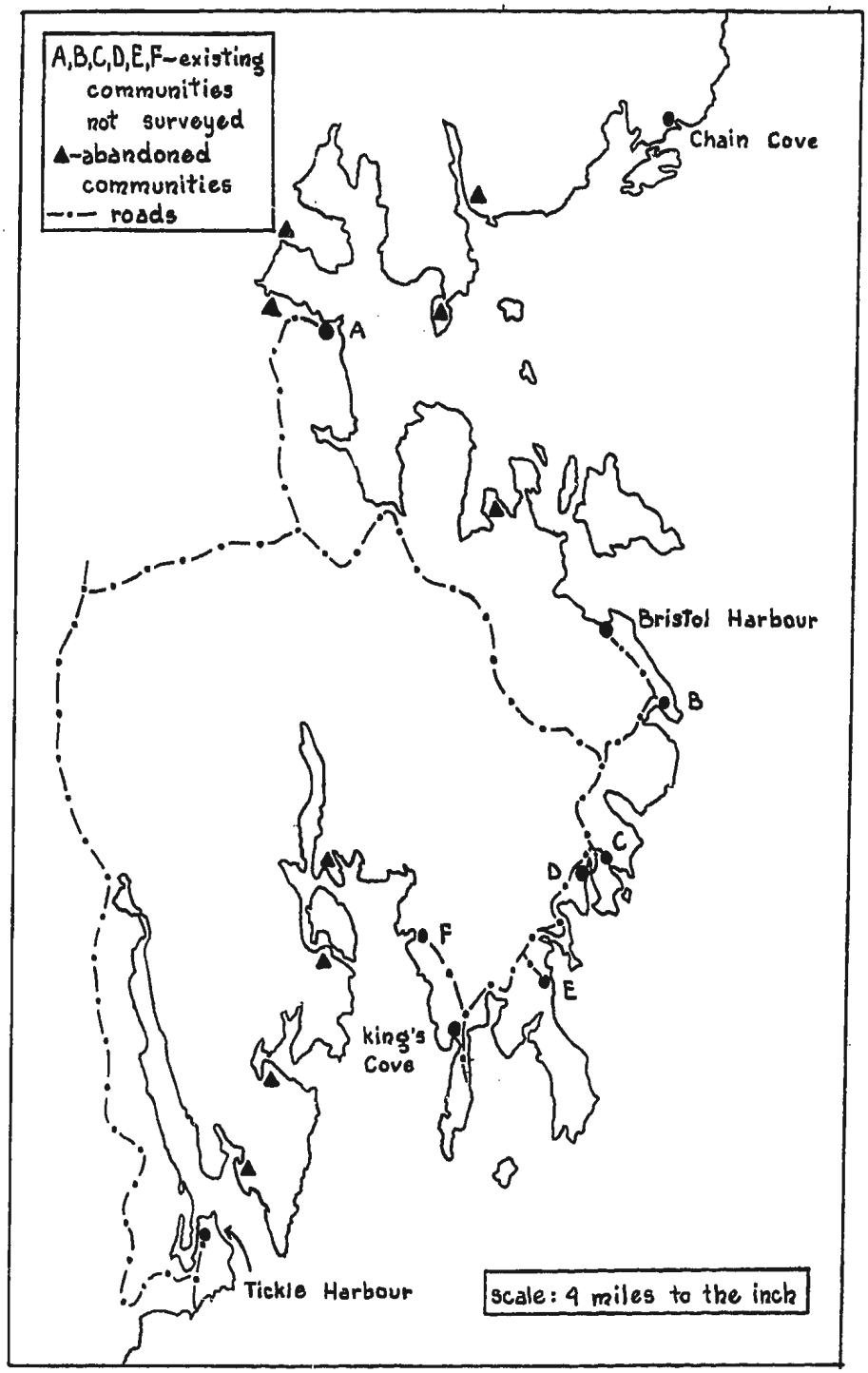

Figure I. The Research Area.

agriculture or even any appreciable stands of timber. Thick underbrush and many small lakes or "ponds" characterize the area, while game is fairly plentiful. All but one community is connected to the others by a system of rough, narrow dirt roads, though the area itself is not connected to any trans-island road system, such as the Trans Canada Highway, which would give it overland access to the larger centers of the province. The sole transportation system is provided by coastal "steamers" operated by the Canadian National Railway. These ships call at each community about three times a week in summer and twice a week in winter, although they are frequently delayed by bad weather, especially in winter, and it is not unusual for a community to go for ten days without a visit. They carry freight and passengers at reasonable rates, as well as the mail, but are frequently over-crowded. These coastal steamers do not give direct access to St. John's or other urban centers, but terminate at a community with road access to the capital.. It is till a 165 mile trip by taxi, 68 miles over dirt road, before reaching St. John's.

The area has always depended heavily on the fishery for its economic support, understandably so, given the lack of other resources. Most consistent utilization has been in the inshore fishery, but there have been periodic booms in the herring seining and processing industry, most recently in the 1920's and 1940's. Also, several communities, especially Bristol Harbour, participated heavily in the schooner fishery on the Grand Banks during the 1900-1930 period, some ships being owned by St. John's merchants but manned locally.

As mentioned previously, four communities were chosen as sites for survey interviewing and deserve closer description. Tickle Harbour (all community names are pseudonyms) is the largest community in the area, with a population of about 1300. It has experienced recent growth due to an influx of people who have resettled from neighbouring communities under the government resettlement program. These people were mostly drawn to the community by the prospect of jobs in the large fish processing plant and supporting fleet of trawlers established here by a mainland firm several years ago. The trawlers provide work for men from all communities in the area as well as for the local residents. Tickle Harbour is almost evenly divided between Anglican and Roman Catholic adherents. There is a large high school and several major stores. The RCMP officer who serves the area is stationed here, as is the magistrate, clergymen of both faiths, and the local offices of the Department of Social Services and Rehabilitation. There is a twenty-one bed local or "cottage hospital" which is staffed by two medical doctors, four registered nurses, a number of trained nursing assistants, and auxiliary staff. Tickle Harbour is incorporated and has an elected mayor and council.

Bristol Harbour, some fifty-six miles away by road, was the researcher's home during the course of the research. It boasts of little in the way of industry, except for the inshore fishery. About forty men are employed, and the catch is trucked to Tickle Harbour for processing. Population of Bristol Harbour is about 600 people, many of whom have moved from surrounding communities, abandoned over the past twenty-five years. The community is dominately Anglican and a priest of that

faith resides there. There is also a medical doctor, designated as District Medical Officer by the Department of Health (provincial) who provides all medical services in the area. The department maintains a fifty-foot launch and crew for the doctor's use. Bristol Harbour is incorporated, with an elected mayor and council. It boasts one of the two public drinking establishments in the area, operated by the local branch of the Canadian Legion.

Ship Cove is a community of 200 people about twenty-four miles from Bristol Harbour and sixty-two miles from Tickle Harbour by road. There is little inshore fishing. Most gainfully employed men work on the trawler fleet at Tickle Harbour or for a merchant in a neighbouring community. The community is mainly Anglican and is served by the minister from Bristol Harbour who holds services there at least once a month. The doctor from Bristol Harbour holds a scheduled clinic in Ship Cove once a month and makes emergency calls whenever necessary.

Chain Cove is the only community in the area not connected to the local road system. Its population of 250 must rely on the coastal steamer even for transportation within the local area. It too is predominantly Anglican and is visited by the Bristol Harbour minister at least once a month and when needed for special occasions such as marriages or burials. The Bristol Harbour doctor holds a monthly clinic and makes emergency calls by means of the launch maintained for that purpose in Bristol Harbour. Unlike Ship Cove and Bristol Harbour, which provide schooling up to and including grade six, the school at Chain Cove covers up to grade eleven. Except for a light involvement in the inshore fishery, most gainfully

employed men travel to Tickle Harbour or other centers for work on the trawlers. Some of the people of Chain Cove have moved there from nearby now-abandoned communities. Now there is talk of Chain Cove itself being abandoned.

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CHAPTER III

HOW OUTPORT NEWFOUNDLANDERS VIEW MENTAL ILLNESS

This chapter is devoted to a general presentation and discussion of the results of the interview survey of the four communities. Comparison on the basis of selected social characteristics of the respondents is dealt with in this section while comparison of sub-groups differing in accessibility to professional resources is the concern of Chapter IV. Data pertinent to the narrower interests of other chapters is discussed in those chapters.

Since I am not concerned with, and do not wish to become involved with, the psychiatric literature and its discussion of the validity of diagnostic "types" of mental illness, the diagnostic labels of the various profiles are not referred to in the discussion. The profiles are referred to by number; the reader may quickly identify these profiles by reference to Table I and/or Appendix I. In analysing the responses to the profiles, I found it useful to sum the responses into a combined profile. In other words, instead of 48 respondents replying to six profiles, the data are treated as if 288 respondents replied to one profile. This technique has weaknesses, of course, especially in terms of weighting and in terms of the implied comparability of the profiles. Despite these faults, I believe that this technique can be used effectively to orgainze data to support trends noted in the individual profiles.

As mentioned previously, the interview format has been used in varying forms in a number of studies. In addition to the original NORC

survey of 3500 randomly selected Americans carried out in 1950 (Star; 1952, 1955), the format was used by Cumming and Cumming (1957) in a small town in Saskatchewan in 1951, with 1700 residents of Baltimore in 1960 (Lemkau and Crocetti, 1962), with 102 urban leaders in New York City in 1960 (Dohrenwend et al., 1962), and in two ethnically diverse communities in Saskatchewan in 1965 (Lafave, et al., 1967). Also, several general surveys of attitudes towards mental illness have been conducted by Nunnally (1961) in Illinois, 1954-59, and by Ramsey and Seipp (1948) in Trenton, New Jersey. Many of these studies report only a limited amount of data, usually owing to the restrictions imposed by reporting in journal articles, or are irrelevant to the concerns of this study. However, they will be referred to wherever applicable.

The Outport View

When asked what kinds of behavior they associated with the term mental illness, the respondents emphasized extremely bizarre behavior, (28 percent), being out of touch with reality or "not knowing what they're doing" (12 percent), and violent or suicidal behavior (24 percent). Lesser emphasis was placed on "immoral" behavior, nervousness, and the expression of physical pathology. Most people thought that there was "something wrong" with each profile, the highest being 96 percent, for profile No. 1. Most people who thought there was something wrong with the profile person thought "something should be done" about him.

When asked for the cause of the profile person's behavior, the respondents favoured such explanations as "bad nerves"; explainable,

benign, normal and acceptable personality traits or moods such as shyness, jealousy, or fatigue; poor family environment; or transplanted labels from another type of pathology, such as "alcoholic". Causes that received less emphasis were fear, either situational or resulting from a traumatic experience; habit or ("ways" in the local idiom); physical pathology and heredity; worry or preoccupation with some problem; and retardation or being "mental". An average of 12.2 percent stated that they did not know the cause of the behavior.

The majority of respondents felt something should be done about the profile person; in other words, they were action oriented to the profile. They were mostly highly action oriented to behavior whose cause was "bad nerves", retardation or being "mental", or bad family environment. They were definitely not oriented to taking action toward behavior the cause of which was habit or "ways", or moods.

Designations of what should be done (help source referrals) were dominated by reference to some sort of professional agent or agency (76.7 percent on the combined profile). Most of these referrals were to medical (including psychiatric) resources, a finding supported by Dohrenwend et al., (1962). Amongst all referrals, the local doctor was the most popular. Amongst the medical groups, the doctor was followed by the provincial mental hospital, and the general hospitals. Amongst the nonmedical referrals, non-professional community resources and professional law enforcement agents were popular. Referral to non-professional resources was associated with identifying the profile as "nothing wrong". Referral categories

were collapsed into those referrals which would or would not entail the individuals exclusion or removal from the immediate local area. Included in the exclusionary category were referrals to psychiatrists, general hospitals, and the provincial mental hospital, all located in St John's as well as referrals to law enforcement agents.[1] Exclusionary referrals varied with the profile, averaging 47.6 percent of the total referrals.

Non-professional referrals were strongly associated with profiles whose behavior was attributed to "moods" or to habit. Behavior caused by "bad nerves" tended to be referred to local professionals, particularly the doctor. Behavior caused by bad family environment tended to be referred to law enforcement officals usually to initiate divorce, and to non-professional means. Those seen as having other pathologies or whose behavior was caused by worry and preoccupation were referred to other professional resources such as clergymen.

Table I indicates the percentage of respondents designating each profile as mentally ill. There is a degree of consistency in the findings between this study and the others. Profile No. 1 is the only one strongly identified as mentally ill in this and other studies. Identifying a profile as mentally ill was strongly linked with identifying it as abnormal (something wrong) and with being action oriented toward the problem. Profiles identified as mentally ill tend to be referred to

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[1]Explicit in the law referrals was the expectation that the individual would be imprisoned and the jail in Tickle Harbour is a temporary, one-celled affair.

TABLE I

PERCENTAGE OF SAMPLE IDENTIFYING PROFILE AS MENTALLY ILL - COMPARATIVE STUDIES

Profile	Outport Newfoundland 1971	Saskatchewan 1951	Saskatchewan 1965	Star U.S. 1950	N.Y. Urban Leaders 1960	Baltimore 1960
#1 Frank Jones (paranoid)	90%	69%	94%	75%	100%	91%
#2 Betty Smith (simple schiz.)	48%	36%	71%	34%	72%	78%
#3 George Brown (anxiety neurotic)	31%	20%	*	18%	50%	*
#4 Bill Williams (alcoholic)	21%	25%	71%	29%	63%	62%
#5 Mary White (compulsive-phobic)	19%	4%	*	7%	40%	*
#6 Bobby Grey (behavior disorder)	19%	4%	*	14%	50%	*
Mean	38%	26%	79%	30%	63%	77%

* profile not used in this study

exclusionary resources more than those not so identified. That is, these profiles were referred to professional medical resources, and most frequently to the provincial mental hospital. None were referred to the hospital in Tickle Harbour, although it is known that this hospital accepts psychiatric patients, at least on a short term basis.

Behavior the cause of which was retardation or being "mental" and behavior for which no explanation could be given (answered "don't know") tended to be most likely labelled mental illness. Behavior caused by habit or mood tends not to be labelled mental illness.

The most frequent reason given for labelling a profile mentally ill was simply the behavior described in the profile. The other main reasons given were actual and potential violence, disruption of the individual's ability to fulfill the more basic expectations of his social role (for example, being unable to work) and incongruity of the individual's behavior when reflected against his social background (eg. - "why should he act like that when he has a good home and family?"). The most common reason given for identifying the profile as not mentally ill was that the behavior was common and normal in the situation. Respondents frequently embellished the profile with additional features that made the behavior appropriate - for example, the alcoholic was given a nagging wife. Other reasons for not identifying the profile as mentally ill were the lack of violence, lack of bizarreness, that there was no serious disruption of role performance, that it was "just nerves" or that the individual had another type of pathology, such as being an alcoholic. Dismissing the

behavior as common or appropriate in the situation was associated with both conventional "moods" and bad nerves as a cause of the behavior. Bad nerves as a cause tended to be retained as a reason for not thinking the person mentally ill.

Of those profiles identified as mentally ill, there was considerable variation as to whether or not the mental illness was serious. Most serious was the mental illness of profile No. 1, (56.8 percent) and least serious was the mental illness of profile No. 3, (12.5 percent); the average was 33 percent. Serious mental illness tended to be referred to exclusionary professional resources much more than non-serious mental illness. The few cases of mental illness seen as being caused by bad nerves were clearly considered not serious. The judgements of the seriousness of each profile's mental illness are similar to the findings of Dohrenwend et al., (1962) and the Cummings (1957).

Although the sub-groups are really too small to make confident generalizations, it appears that the main reason for considering a profiles's mental illness serious is actual and potential violence and danger. The main reason for not seeing the mental illness as serious is the lack of violence and bizarreness and the perceived ease of treatment. It was also decided to look at the degree to which each profile person was defined as responsible for his behavior rather than the victim of a pathogenic environment or circumstances beyond his control. Causes given for each profile person's behavior were divided into the categories of individualistic and environmental. On the first five profiles, responsibility was overwhelmingly seen to be the individual's. On profile No. 6,

that a young boy, responsibility was largely attributed to the environment. The only association between type of cause and type of referral was between individual responsibility and referral to medical professionals. Referrals were coded as to whether they were aimed at the individual or his environment. There seemed to be no relationship between type of cause and these two types of referrals.

The causes of "going out of mind, going insane" were mostly individualistic, more so than the causes of "nervous conditions". Respondents were much more optimistic about the chances of recovering from "nervous conditions" than from "insanity": results closely paralleled by those Star (1955) reports. Nunnally (1961) found that most of his sample felt little could be done for someone who was "insane".

Most respondents (68.8 percent) thought that an individual needed help to get over a "nervous condition" while 16.7 percent felt they could recover by themselves and 12.5 percent indicated a combination of help and self-reliance were needed. In contrast, only 2.4 percent of the sample indicated any form of self-reliance was effective for the insane person's recovery.

About the same proportion (40 percent) felt that "nervous conditions" could be prevented as felt "insanity" could be prevented. Individuals who felt one could be prevented were usually optimistic about the prevention of the other. However, they were much more likely to rely on professional resources, usually medical, for prevention of "insanity".

When confronted with the problem of a family member acting

abnormally, 78.7 percent of the respondents advocated referral to professional resources and 19.1 percent to non-professional resources. Those who would not make an initial referral to psychiatric resources were presented with the hypothetical possibility that their initial course of action would not be successful and asked what they would do next. One hundred percent of the secondary referrals were to professionals. Changes from initial to secondary referrals were as follows; the provincial mental hospital referrals increased from 2.2 percent (a rate similar to Star, 1952) to 26.2 percent; general hospitals increased from nil to 7.1 percent; local doctor referrals decreased from 69.6 percent (rate similar to Lafave, et al, 1967) to 14.3 percent; and psychiatrists increased from 6.5 percent to 40.5 percent. Referrals to the local hospital decreased and referrals to law enforcement agents increased. General exclusionary referrals increased from 8.7 percent to 76.3 percent.

The sample population heavily favoured professional resources for the treatment of "insanity". Their most popular help-source for the management of this problem was the provincial mental hospital (73.2 percent). Non-professional resources, the local doctor, general hospitals, and the cottage hospital in Tickle Harbour were all considered of minimal importance in treating "insanity". Star (1955) reported that 56 percent of her sample recommended mental hospitals and/or psychiatrists, much less than the 78.1 percent in the current study. Of the total referrals for the treatment of "insanity", 83 percent were exclusionary.

The great majority of the respondents (95.7 percent) felt, when asked directly, that the "insane" should be placed in a mental hospital.

Their reasons for this divided almost evenly into two categories of response; a custodial orientation ("to protect the public") and a treatment orientation ("only place they can get help").

Most of the sample population thought that the mentally ill had at least a chance of getting better but a substantial minority felt that they could not. The reasons for not getting better were mostly traced to the individual. Most (85 percent) felt that the mentally ill individual could never completely recover, but would always show signs of his illness.

The majority felt that a mentally ill person was dangerous, mostly because of potential violence. Respondents who regarded the mentally ill as dangerous also tended to feel that they could not be completely cured and should be placed in a mental hospital for custodial rather than treatment reasons. In addition to the fear of violence, ten respondents felt that the mentally ill individual could have a negative psychological effect on those around him.

When presented with the situation of discovering that a fellow community member had been treated for mental illness, a slight majority of the sample admitted that they would feel differently about this individual. Those who stated that they would feel the same also tended to believe that the mentally ill could be cured, and completely so. The opposite was true of those who stated that they would feel differently about a community member who was an ex-patient.

The different feeling was mostly mistrust or fear, but a minority stated that they would feel more sympathetic. Those who said

they would be fearful also felt that ex-patients would always show signs of illness and expressed a custodial orientation to mental hospitals. As far as acting towards an ex-mental patient is concerned, 58.3 percent stated that they would treat them no differently, results similar to those of Star (1952). "Treating" differently tended to be more sympathetic than "feeling" differently, leading to the suspicion that much of the solicitude was motivated by fear.

Respondents were almost evenly split on the question of when to see a psychiatrist, 45.8 percent feeling that one should be consulted at the first sign of a disturbance and 43.8 percent feeling that one should be consulted only when the problem was quite serious. Three individuals volunteered that they had never heard of a psychiatrist before.

Only 25 percent of the sample population stated that they knew of an individual whom they felt should see a doctor about a "mental problem". The main reason given for why this individual had not consulted a doctor was that he or she did not realize that they needed help. A minor reason given was that the individual's peers tolerated his behavior.

As mentioned previously, various sub-groups of the sample population were compared in order to assess the influence of various social characteristics on the responses to the interview questions. Despite the crudeness of the comparison and the smallness of the samples, the data seem to indicate that generally, these characteristics have little direct bearing on the attitudes and conceptions of the population. However, a few striking differences are perhaps worth mentioning.

Because of the predominance of Anglicans in the sample, religion was not used as a comparative base. The mean age of the sample was 45 years, so those 45 and younger were contrasted with those over 45. The younger group tended to refer the profile persons to local professionals while the older group referred them mostly to non-local professionals. The younger group tended to see the causes of "insanity" as less individualistic than the older group, and was less prone to refer individuals to the mental hospital. Older persons are more likely to treat an ex-mental patient differently and to know someone who should see a doctor about a "mental problem".

Because of the method of selecting the sample, males and females in it were of almost equal number. Females tend to attribute responsibility for all varieties of behavior to the individual while males tend to attribute it to the environment. Females are more action oriented, and refer the cases more to the local doctor and less to law enforcers than do males. Males make more exclusionary referrals than do females, but females regard mental illness as more serious and place greater emphasis on the violence of the mentally ill. Males prefer non-professional preventive measures while females prefer professional measures, especially the local doctor.

The mean educational level of the sample was six full years of school. Those with six years of schooling or less were compared with those having more than six years. The more educated offered "bad nerves" as a cause of profile behavior less frequently than the less educated group did. The more educated showed a greater tendancy to refer cases

to psychiatrists and to refer to them earlier. The less educated tended more often to feel that the mentally ill were dangerous. The higher educational group were less likely to treat an ex-mental patient differently, but when they did, they did so with greater fear.

Any standard method of determining social class, such as occupational ranking scales, would be inapplicable in a rural setting so different from the urban settings in which such techniques are usually developed. A crude index of socio-economic status was achieved by dividing the sample into those whose financial support is gained by wage labour and those supported by transfer payments.[2] The lower socio-economic group were more prone to dismiss as common or normal behavior potentially definable as mental illness and they displayed a stronger tendancy to utilize non-professional help-sources. They were also willing to wait until a disorder became more severe before consulting a psychiatrist.

Although I avoided asking any direct questions about a respondent's personal involvement with psychiatric treatment, ten members of the sample population volunteered the information that they or a member of their immediate family had received such treatment. Despite the smallness of this group, and the impossibility of judging the prevalence of unrevealed experiences of this type in the larger group, it was decided to compare the two groups and note any differences outstanding.

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[2]The major weakness of this approach is that receiving social assistance, may, under certain circumstances, bring an individual more cash income than he might have earned in the inshore fishery.

The "experienced" group showed a greater tendency to cite bad nerves as a cause of abnormal behavior and less reliance on mere reiteration of the profile behavior as a reason for calling the behavior mentally ill. They relied more heavily on the incongruity between background and behavior. The "experienced" group placed much less emphasis on bizarre behavior as characteristic of the mentally ill and were less optimistic about the chances of preventing neurosis.

Discussion

The sample population seems to define as mental illness, or at least attachs to that term, behavior that is violent, bizarre, and of potential danger. Behavior of this type is evidence of illness in itself, but the emphasis is also on the unpredictability of this behavior, as illustrated by the frequent comment "you never know what they might do". This emphasis is evident in the extension of the mentally ill label to those individuals whose behavior is incongruous with, and thus not predictable from, their social background. Mental illness is to a certain extent, seen as a causative rather than a caused phenomena in that it rationalizes behavior otherwise unexplainable. The great emphasis on violent, grossly bizarre, and "out of touch" behavior indicates that, at least for the sample, the term "mental illness" usually refers to psychotic states rather than milder neurotic states. There also seems to be little conception of psychosomatic aspects of mental illness, although local physicians report contact with a large number of such cases.

The conception of mental illness as being characterized by

violent, bizarre, unpredictable, and unexplainable behavior jibes with impressions gathered while living in the research area. This conception is best illustrated by one particularly dramatic incident.

> A young, married man, whom I will refer to as John Lee, had been living in the community for about two years and was the center of much gossip and negative discussion because of his allegedly prolific sexual relations with a number of younger girls. One morning it became known throughout the community that the previous evening the RCMP patrol boat from "across the bay" had arrived and the officers had removed John Lee, in custody, to St. John's. Of course, such a dramatic event soon became the subject of much discussion and speculation. The story of John Lee's removal varied with the teller, but the basic theme was that he had entered a house in the community and had made overt and aggressive sexual advances to a young female babysitter and then to the female head of the household, only to be interrupted by the woman's husband who subsequently laid charges.
>
> Within another 24 hours it became known that John Lee had not been arrested to face criminal charges but had been forcibly taken to the provincial mental hospital. Almost immediately, the "story" of what had happened changed drastically. It now became commonly understood that John Lee had entered the house mumbling incoherently and weeping, had threatened the young girl and adult woman repeatedly with a knife, and then gone upstairs where he inflicted apparently meaningless damage to the furnishings, with the knife.

Neither of the two "stories" were in fact true. The interesting point is that the recollection of John Lee's behavior shifted to fit his identity as mentally ill and his imputed behavior as a sexual deviant. was seen as inappropriate to the popular definition of mental illness. There was the tendency for individuals, in discussing the affair, to, remind their listener, that they had in the past, "told you there was something mental about that fellow" and to cite incidents in John Lee's past behavior that had seemed "mental" to them (in the interests of diplomacy, I did not remind these individuals that they had told me no

such thing.) The attachment of the deviant, or in this case, mentally ill label and the retroactive construction of a history of abnormality consonant with the label are discussed by Goffman (1961) and Kitsuse (1962).

While the interview data indicate that the outport population is not lax in detecting abnormality ("something wrong") in the behavior of other individuals they also indicate that outporters tend to search for means of normalizing this behavior so that it falls short of mental illness. As long as behavior is logical, motivated, and benign, it is explained in a number of ways such as moods, common variations in character, or bad nerves. Only behavior that fits the extreme definition of mental illness presented previously, is so labelled.

Obviously, the lay population is far from sharing the professional psychiatric definition of mental illness. The only profile on which there is agreement is that of the violent, paranoid man; (he came closest to the popular definition of mental illness held by the respondents.) This profile was also considered to have the most serious mental illness .

Contrary to findings by Star (1955), whether or not an individual is responsible for his behavior seems to have no relation to being or not being considered mentally ill.

Identification of behavior as abnormal seems to include the expectation that some action will be taken towards the individual to redress his abnormal behavior. Taking action usually means placing the individual in contact with some sort of professional "treating" or social control agent or agency. Non-professional, interactive help-mechanisms

are usually reserved for redressing minor mood-swings, which are explained by situational forces. Of those identified as abnormal, those labelled as mentally ill are usually referred to help sources somewhat different from those to which the not-mentally ill are referred; help sources which usually entail the exclusion of the mentally ill from the immediate area. The degree of exclusion depends on the perceived seriousness of the mental illness in question; in other words, on how closely the behavior fits the popular definition of mental illness. Reactions to ex-patients seem to indicate a degree of exclusion even within the community.

Care of the mentally ill is seen as the province of medical-psychiatric professionals, particularly at the provincial mental hospital. Exclusion from the community is not a completely automatic reaction to abnormal behavior. At least in the family (and it is reasonable to expect that most referral decisions are made here) there is a tendency to utilize local professional and non-professional resources initially and to move to more exclusionary resources if the initial referral is unsuccessful.

Use of treatment facilities and general attitudes towards mental illness show a slight tendency to be affected by social characteristics. Older persons' greater reliance on non-professional and non-local professional resources perhaps reflects an orientation of a recent era when local professional resources were practically nonexistant. The greater emphasis by females, on the violence of mental illness and its subsequent greater seriousness, possibly reflects the fact that this type of behavior has far more serious implications for females than for their

stronger, more aggressive male counterparts. The lower socio-economic group's relative reluctance to use professional resources probably reflects their perception of the economic costs of these services. Education bring an increasing awareness of and orientation toward the use of psychiatric services.

Attitudes towards and patterns of reacting to the mentally ill are a function of how the individual conceives of the nature of mental illness and its victims. Most view the mentally ill as dangerous, are pessimistic about the chances of recovery and see professional referral as a means of controlling, rather than changing, the individual's behavior. Given this view of mental illness, it is not surprising that the ex-mental patient is treated with fear, suspicion, and/or increased solicitude. A more positive minority view sees the mentally ill as not necessarily dangerous, and able to recover completely if treated professionally.

CHAPTER IV

THE DISTANCE EFFECT

Urbanization, Distance, and Accessibility

It has been repeatedly shown that rates of admission to both general and psychiatric hospitals may vary amongst certain geographical areas; amongst areas of the same city (eg. Cohen et al, 1939; Dawson, 1911; Faris and Dunham, 1939); and with certain demographic and social characteristics such as age, sex, marital status, native or foreigh birth, economic status, and level of education (Dayton, 1940; Fandet, 1936; Malzeberg, 1930; Hollingshead and Redlich, 1958). One of the most consistent trends found in this type of research has been the higher rate of first admissions to both general and psychiatric facilities for persons of urban residence as opposed to those of rural residence.[3] Considering 90,000 first admissions to general hospitals in the United States, Odoroff and Abbe (1957) found rates, per 1000 populations, of 101 admissions for urban areas and 83 for rural areas. Buck et al (1955a) found a similar difference for 1983 first admissions to psychiatric facilities from 14 counties of western Ontario.

The traditional view of this phenomenon at least as far as psychiatric admissions are concerned, has been that these rates reflect

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[3]First admission data are generally used because readmission data can involve counting the same individual more than once in any given time period.

more or less accurately the prevalence of mental illness in the different populations studied. Differences in the prevalence of mental illness were seen as functions of pathogenic aspects, such as social disorganization and stress, of the particular social situations characteristic of these populations (eg. Faris and Dunham, 1939; Jaco, 1954, 1959).

Work by sociologists and social psychiatrists has shown, however, that at least in professional psychiatric terms, many populations studied have high rates of undiagnosed and untreated mental illness (eg., Leighton et al, 1959; Hollingshead and Redlich, 1958). Of the 17.2 cases of psychosis per 10,000 population identified by Kaplan et al (1956), in an area of Boston, 6.7 cases per 10,000 of these individuals had never been previously treated.

If any hopes were retained by social psychiatrists that first admission rates could be used as an indicator of the prevalence of mental illness, these were dashed by Eaton and Weil's (1955) study of the Hutterites of midwestern North America. Attracted to this group by their extremely low rate of psychiatric hospitalization, the researchers discovered that the Hutterites total prevalence of pathology (treated and untreated cases, again according to psychiatric definition) exceeded that of seven out of eight comparative populations from all parts of the world. The researchers were forced to conclude that the rate of psychiatric admissions in no way reflected the prevalence of mental illness within the population.

It appears that we cannot assume that higher urban rates of admission to psychiatric facilities reflect a greater prevalence in urban

areas of individuals who are mentally ill, or at least would be considered so by a psychiatrist. Researchers who have more carefully studied the dimension of geographic location in relation to hospital admission rates, have found a relation between these rates and distance from the admitting facilities. Odoroff and Abbe (1957) found that admissions to general hospitals decreased as the distance to these hospitals increased, Conner and Davidson (1967) compared two small communities in Nova Scotia and found that the population of the more isolated community were less likely to seek medical aid and would tolerate more discomfort before doing so than their counterparts with much easier access to medical facilities. For psychiatric admissions alone, Buck et al (1955a) found a strong negative relationship between distance from mental hospitals and incidence of first admissions. They also found a positive relationship between the ratio of physicians in the population and the rate of first admissions to psychiatric facilities. Whitmer and Conover (1959) identified a number of factors precipitating psychiatric hospitalization, the most outstanding being contact with a physician.

It seems that, at least in terms of the above research, utilization of medical and psychiatric facilities by individuals is determined, to some degree, by the proximity and ease of access of these facilities. This relationship can be used as a hypothetical explanation for higher urban rates of first admissions to psychiatric facilities. There seems to be some support for the contention that urban-rural variations in first admission rates are, in part, a function of the centralization of medical and psychiatric facilities in these urban areas, a pattern

characteristic of much of the western world. In Newfoundland, for example, at the time of the study, all but one of the psychiatrists, and most of the in-patient psychiatric facilities in the province were located in the capital, St. John's. The remaining psychiatrist and other major psychiatric facility were located in Corner Brook, the second largest city in the province.[4]

Table II presents the psychiatric first admissions per 1000 population for Newfoundland Federal Census Divisions (see Figure II) for 1969, the most recent tabulation available (Dominion Bureau of Statistics, 1969a). Division I, including St. John's, and Division V, including Corner Brook, have the highest admission rates for the province. However, a rough index of urbanization calculated by percentage of population living in communities of 1000 or more, reveals that neither of these census divisions is the most urban in the province.[5] The most urban area, Census Division VI, has a first admission rate below the provincial average. Census Division X (Labrador) has the lowest rate of admissions in the province but is the third most highly urbanized.

It would be unrealistic, given the lack of comprehensive data and the non-epidemiological focus of this study, to attempt to evaluate the degree to which each census division in the province is isolated from psychiatric facilities. However, it should be noted that what Figure II

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[4]A small 10-bed unit operated by the International Grenfell Mission opened in St. Anthony's for part of 1971.

[5]Admittedly, this measure of urbanization is not comparable to normal methods used in mainland North America, but is dictated in Newfoundland by both the nature of population dispersal, and the data available.

TABLE II

COMPARISON OF FIRST ADMISSION RATES TO PSYCHIATRIC FACILITIES AND DEGREE OF URBANIZATION FOR CENSUS DIVISIONS OF NEWFOUNDLAND AND LABRADOR, 1969.

Census Division	First Admissions/ 1000 Population	% of Population in Communities of 1000 or More
I	1.15	62.3%
II	.75	39.1%
III	.81	50.0%
IV	.85	45.4%
V	2.23	74.2%
VI	.69	83.6%
VII	.73	27.9%
VIII	.67	27.1%
IX	.54	14.7%
X	.45	67.5%
Provincial Average	.95	49.1%*

* Calculated by summing total number of individuals in province living in such communities, and dividing by total population of province.

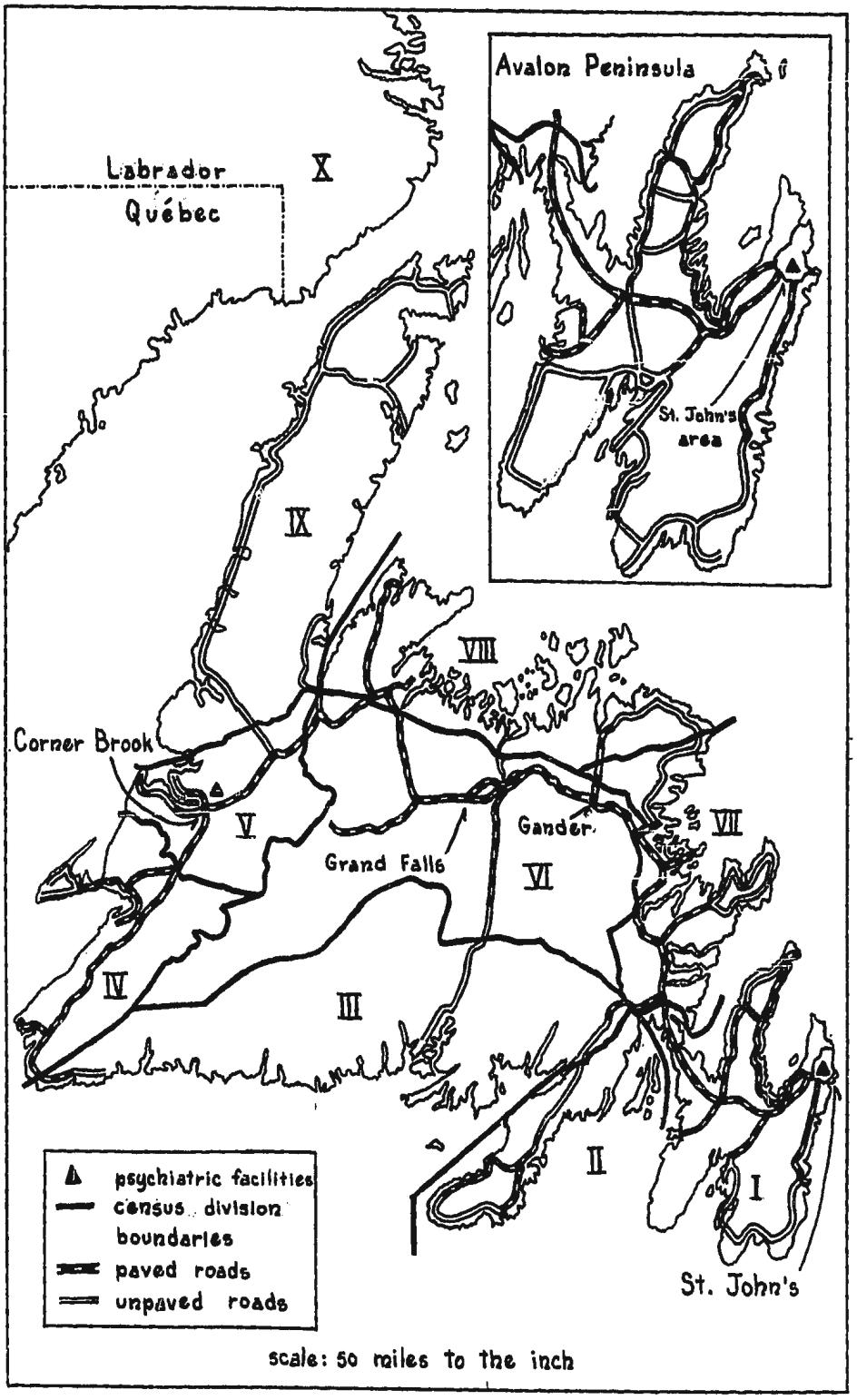

Figure II. Province of Newfoundland and Labrador showing major centers and Federal Census Divisions.

shows as, and what are commonly accepted to be, amongst the most isolated regions of the province, Census Divisions IX and X, have the lowest first admission rates for the province.

C. S. Mellor (1972) has prepared a geographic analysis of first admission rates to the provincial mental hospital at ten-year intervals running from 1901 through 1970. This analysis gives a historical picture of the geographic distribution of admissions by calculating the number of times the admission rate for each census sub-division has exceeded the provincial average. The analysis reveals that Census Division V, the area with the highest admission rate in 1969, has historically had one of the lowest admission rates in the province, some sub-divisions never once exceeding the provincial average in the seven sample-years covered. Is it not plausible to hypothesize that the recent dramatic upswing in psychiatric admissions from this area is in some way, related to the introduction of psychiatric facilities to Corner Brook in 1965? A lack of data prevents a comprehensive analysis of admissions from Census Division V for each year preceeding the following the introduction of these facilities. The available information shows that the admission rate for 1962 was .76 persons per 1000 population, below the provincial average of .78 persons per 1000 population, and well below the 1969 rate of 2.23 persons per 1000 population.

Mellor's historical analysis shows that the area in and around St. John's, where psychiatric facilities have been located since 1855, has consistently had the highest admission rates in the province, exceeding the provincial average on every tenth-year studied. This trend is not confined to the city itself, but is characteristic of areas near the city

which are predominantly rural.

A special tabulation provided by Statistics Canada enables us to examine, in some detail, rates of first admissions (1965-1969) from the census division of which the field study area was part, in comparison with urban St. John's. The small number of admissions (113) from the field study area made comparison of individual communities impossible. Thus the admissions were categorized as originating in communities with doctors or hospitals or both, and as originating in communities without these services. The rate of first admissions for the five-year period was higher (5.88 persons per 1000 population) for communities with medical facilities than for communities without them (2.79 persons per 1000 population). The highest admission rate was for the residents of urban St. John's; 6.81 admissions per 1000 population.

Buck et al (1955b) reason that if higher urban admission rates are caused by a difference in demand for hospitalization, the urban excess should manifest itself predominantly in the rate for cases whose symptoms are sufficiently tolerable socially that care outside the hospital would be possible. They were able to support this hypothesis through a sophisticated analysis of the reported symptoms of admitted patients. A somewhat cruder analysis applied to the admission data for the research area census division appears to support further this contention. Here, it was assumed that the general diagnostic term "psychotic" usually represents the extreme in behavioral manifestation of psychological disorder. The Diagnostic and Statistical Manual of Mental Disorders (1969) tells us how psychiatrists visualize psychosis:

> Patients are described as psychotic when their mental functioning is sufficiently impaired to interfere grossly with their capacity to meet the ordinary demands of life. The impairment may result in a serious distortion in their capacity to recognize reality. Hallucinations and delusions may, for example, distort their perceptions. Alterations of mood may be so profound that the patient's capacity to respond appropriately is grossly impaired. Deficits in perception, language, and memory may be so severe that the patient's capacity for mental grasp of his situation is effectively lost.

In the period 1956 through 1969, psychotic disorders (by admission diagnosis) made up 44.2 percent of all first admissions to psychiatric treatment facilities from the city of St. John's. For same period, psychosis made up 57.3 percent of all admissions from the predominantly rural census division in which this study was conducted. Most of the variation was caused by admissions from communities without medical facilities, psychotics makeing up 63.8 percent of them. The rural communities with medical facilities had a rate of psychotic admissions slightly higher than that of St. John's.

Thus, data from Newfoundland seems to support the hypothesis that access to professional medical and psychiatric facilities has some effect upon the numbers of people who use these facilities as well as on the types of problems they use them for. Also related to this problem is a comprehensive survey by geographer John Girt (1971) on medical consulting behavior in rural Newfoundland, which attempted to determine the effects of distance from local medical facilities on the propensity to consult with a doctor for specific problems. He found an overwhelming tendency to consult with local rather than non-local doctors, even for quite serious problems (thus further illustrating the exclusionary aspect of the referrals of the mentally ill mentioned in Chapter III).

Girt also found that increasing proximity to a doctor increased the tendency to consult the doctor the first time, as well as the tendency to make repeated visits. Respondents admitted, as did those in the study by Conner and Davidson (1967) that the distance to the doctor and its implications for economic cost, time, and discomfort of travel, had a limiting effect upon their decisions to consult. Girt was forced, however, to reject his model of distance in miles, because his data showed that distance became relevant only in communities more than ten miles from the doctor. Up to ten miles, consultation was greater than in the doctor's community itself. He attributed this to an anxiety effect caused by isolation, which was overridden by the distance effect after ten miles.

From experiences in the research area, I believe that the explanation lies more in the nature of the pattern of consultation exhibited by individuals from communities fairly near but not containing medical facilities. In this situation, individuals commonly recruit neighbours to accompany them on the trip to the doctor, thus sharing in both the taxi expenses and in what is regarded as an excursion and a chance to visit kin. Beyond short distances, however, increased costs as well as considerations of the time and discomfort of the trip reduce interest in accompanying a neighbour to the doctor.

Whatever the reason, and despite our concern, in this study, with communities more than ten miles apart, Girt's findings do underscore the difference between distance and accessibility. Pure linear miles do not adequately account for individual decisions to consult a doctor. Varying

economic levels, cost and availability of transport, and certain cultural patterns, such as those just described, make perceived accessibility a much more fluid and individual dimension than mere numbers of miles.

Further support for the contention that accessibility of medical resources affects their utilization is offered by medical practitioners themselves. Conner and Davidson (1967) report that physicians attributed differential consultation patterns to accessibility and even correctly predicted what types of problems would be most affected by this factor. Doctors interviewed during the present study also showed this kind of awareness. As one physician in Tickle Harbour put it, "I would'nt see half the people I do from this harbour if I lived ten miles away".

Conner and Davidson's (1967) physicians believed that consultations for psychological problems and for illnesses of old age would be the problems most effected by accessibility and other data in their study bore them out. An examination of Girt's data (1971) shows that "anxiety states with associated somatic symptoms", the only diagnostic category used in the study that is mainly in the area of psychological disorder, dropped form 10.9 percent of total consultations in communities with medical facilities to 6.5 percent of total consultations from the remote communities.

The Effects of Isolation on Conceptions of the Mentally Ill

In the present study, Ship Cove and Chain Cove (Figure I) were chosen to make up the sample of respondents with relatively low access to medical and other facilities. Ship Cove is approximately sixty-two

miles from the cottage hospital at Tickle Harbour and twenty-four miles from the doctor at Bristol Harbour, over roads that are unpaved, rough, narrow, winding, dusty in summer and ice-covered in winter. The doctor from Bristol Harbour visits the community one day a month to hold a public clinic, at which he conducts physical examinations and dispenses medication. The clinics are well attended and seem to serve a social as well as a medical function. All other contact with medical agents must be made on the initiative of the patient. If the patient can convince the doctor by phone of the aboslute necessity of a special visit, the doctor will return; otherwise the patient must travel to Bristol Harbour himself to see him. In either case of special consultation, the patient must pay the costs of transporting either himself or the doctor. The "taxi" fare from Ship Cove is ten dollars to Bristol Harbour and thirty-two dollars to Tickle Harbour, considerable sums in a setting with relatively low cash incomes.[6]

Chain Cove, not connected by road, is also the site of a monthly clinic held there by the Bristol Harbour doctor, who travels to the

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[6]Since only a small number of householders own an automobile-fewer than 10 percent in Ship Cove - they usually extend free driving services only to their close kin, limiting what would otherwise be numerous and overwhelming requests for these services. Also, vehicles are thought of as a resource by which to partially offset their purchase price and maintenance costs, making most car-owners part-time taxi-drivers. Fare rates are justified by the owners in terms of the rapid deterioration of the vehicles on the rough roads. Rates are fairly inflexible and commonly understood, dictated perhaps by a reluctance to underprice the merchant who is usually not only a powerful person in outport life but also the major taxi-driver. The relationship between passenger and driver is accepted. Few individuals would accept even a casual ride without being able to offer the appropriate fare.

community on the Department of Health launch. Special visits by the doctor, if he can be convinced of their necessity, are again at the expense of the patient; that is, fifteen dollars. It is extremely difficult for a patient to reach Bristol Harbour since the only boats available in Chain Cove are open dories which can only make the trip under the most favourable of weather conditions. Bad weather often prevents the Department of Health launch from sailing or it may be absent from the area on other government business. Coastal boat services are sporadic and also at the mercy of the weather, although the steamers are diverted from their regular route for medical emergencies.

Tickle Harbour, site of the local hospital and center of other facilities, and Bristol Harbour, home of a physician, were chosen to make up the comparative group of respondents with relatively easier access to medical facilities. Before proceeding to the comparative data, however, a few qualifying statements are needed.

Consideration of the economic costs of consulting a doctor may be mitigated by two factors. Firstly, recipients of certain types of transfer payments (such as social assistance) may have all or part of their medical expenses, including transportation, paid for by the agency from which they receive their stipend. Secondly, if one individual can convince the doctor to make a special visit to a patient, other individuals will usually make use of the doctor's presence, for a fractional proportion of the transportation costs. They are not likely, however to accompany others on the long and difficult trip to Bristol Harbour unless they define their symptoms as particularly serious.

It is obvious that sheer cost and difficulty of transportation are not the only consideration when discussing accessibility of medical resources.[7] Particularly in the case of Chain Cove we must be aware of the often complete availability of medical services. Physicians are difficult to attract to rural Newfoundland, rarely stay for more than one or two years, and many months may elapse before they can be replaced. When I visited Bristol Harbour in January of 1972, the doctor had left and had not been replaced; one of the doctors at Tickle Harbour was away on vacation, thereby reducing the medical services to more than 5000 people by two-thirds. Since the doctors are salaried employees of the provincial Department of Health, their earnings bear no relation to the number of patients they treat, making it of no economic value to a doctor to make his services more readily available to prospective patients.

The size of the sub-groups (twenty-four) limited the generation of hypotheses about trends in the interview data but some were still dramatically evident. The group with greater access to medical facilities tended to see the causes of abnormal behavior ("something wrong") as more the responsibility of the individual than did the group with lesser access to medical facilities. The sample with greater access tended, more than the group with lesser access, to refer profile persons, whether merely abnormal or mentally ill, to law enforcement agents. Respondents with low access to medical facilities made more referrals than high access respondents to "other professionals," especially the clergy,

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[7]As far as the patient is concerned, medical services themselves are free, under Medicare, but drugs are not.

for dealing with abnormal behavior. Lesser access respondents showed a much greater dependence on non-professional community resources and a much lesser dependence on the local doctor than those respondents with greater access to medical resources. However, when dealing with profile persons identified as mentally ill, lesser access respondents showed little dependence on non-professional help-sources. Lesser-access respondents showed lower reliance on professionals for dealing with abnormal profile persons but showed a greater reliance on professionals in dealing with mentally ill profiles, than did greater-access respondents. Profiles identified as abnormal were excluded more by greater-access respondents but profiles identified as mentally ill were excluded more by the lesser-access respondents. The lesser-access sample shows less exclusion of the abnormal family member than the greater access sample, but are less optimistic about the recovery, and its completeness, of someone suffering from insanity. The lesser access respondents make more referrals of the "insane" to the provincial mental hospital and have a stronger custodial orientation to that institution than the greater-access group. The group with greater access to medical facilities are more likely to know someone with an untreated "mental problem" than the lesser access group.

What effect does low access to professional medical services have on outport populations? Obviously, isolation is reflected in different patterns of utilization of these resources. Low access seems to strengthen the tendency to deal with abnormal individuals within the community. Yet low access also seems to increase the tendency to rely on professional, exclusionary help-sources when dealing with individuals identified as mentally ill.

This seeming paradox can be resolved by examing the actual conceptions held of what constitutes mental illness. Although Girt (1971) assumed that all outporters share the same conceptions of physical illness, Conner and Davidson (1967) report that in Nova Scotia actual conceptions and definitions of illness were effected by the accessibility of medical facilities. They found that the more isolated populations were more likely to suffer severe incapacitation before defining their symptoms as illness. This is particularly true of psychological disorders, which are more likely to be dismissed as quirks, moods, or non-serious "personal problems". Examination of the data from the present study reveals that the population with lower access to medical facilities seems to hold a different, or at least narrower definition of what constitutes mental illness behavior. In reply to questions such as "what are mentally ill people like?" and in reasons given for identifying a profile as mentally ill and as seriously mentally ill, there is a much greater emphasis by the low access group on such characteristics as violence, bizarreness, and suicide, with a consequent lesser emphasis on immorality, nervousness, and incongruity of behavior with background. On five of the six profiles, the sample with low access were significantly less prone to identify the profile person as mentally ill. It appears that these more isolated respondents tend to tolerate more abnormal behavior - thereby avoiding labelling it mental illness - than do respondents with greater access to professional facilities. Toleration of abnormal behavior and dealing with it within the community is functional, in that it lowers the need for consulting with distant professionals. But toleration also means that only extreme manifestations of disordered behavior come to be recognized as mental illness, and when this behavior is finally labelled as mental

illness, its implications for the safety and well being of the rest of the community may have grown serious, necessitating professional management and exclusion from the area. This pattern is reflected in the relatively greater proportion of psychotics admitted to hospitals from these areas.

Accessibility to professional resources appears to affect not only how individuals react to and manage mental illness and other deviant behavior, but also the conceptions held of what constitutes these types of behavior. Data from other research suggest a further hypothesis. Conner and Davidson (1967) point out the similarities in both conceptions and management of illness between their entire isolated sample and the lower socio-economic group in the community with medical resources. Kaplan et al (1956) and Hollingshead and Redlich (1958) present data that indicate that lower socio-economic groups hospitalize fewer individuals whose symptoms could be tolerated outside the hospital. The present study has shown that the lower socio-economic group were less prone to make use of professional facilities. These statements suggest that utilization of professional services is dependent to some extent, on the economic status of the individual who must decide whether to use these services or not. This point is further supported by Avnet (1962) who found that having insurance coverage for the costs of psychiatric treatment encouraged individuals to seek such treatment. Thus not only availability but also cost and other factors seem to affect the use of professional medical and psychiatric services. It is reasonable to hypothesize that not only patterns of reacting to social deviance (in this case mental illness) but also, actual conceptions of what constitutes deviant behavior will depend to some extent upon the

implications for the definers and reactors of attaching the deviant label.

CHAPTER V

ALTERNATIVES TO MENTAL ILLNESS

We have come to realize that in every culture there are categories or types of social actors, usually denoted by a label such as "father", employee", or enemy". Each of these categories has attached to them expectations not only of behavior appropriate to the individual placed in these categories, but also of behavior appropriate to others in interacting with this individual. This phenomena of social life has been illustrated in the previous pages for the category of individuals defined by their fellows as mentally ill. At least in the area studied in outport Newfoundland, the mentally ill are expected to be unpredictably violent, bizarre, and to exhibit generally disruptive and often dangerous behavior. The appropriate way of reacting to individuals in the mentally ill category is with fear, suspicion, rejection, and referral to distant professional control.

Some literature which has dealt with the social process of entering this category, of coming to be defined as mentally ill, has treated the status-passage from "normal" to "mentally ill" as a sharp break, a one-step reidentification. In this view, entry into psychiatric treatment is the event which prompts the attaching of the mentally ill label. Cumming and Cumming (1957) described their Saskatchewan informants as seeing a sharp break between normal and mentally ill behavior - all behavior was seen as normal up to the event of psychiatric hospitalization. Goffman (1961), in seeking a pragmatic definition of mental

illness, stated that the mentally ill are those who are treated for mental illness.

Other literature (Clausen and Yarrow, 1955; Whitmer and Conover, 1959; Myers and Roberts, 1959) has dealt with the denial, accommodation, and rationalization, usually within the family, of behavior that later was defined as mental illness. This documented pattern of resistance to the mental illness label leads one to feel that the process of identification of the mentally ill is not as simple as others have described it.

Data presented previously in this report show that there are numerous categories into which the interview respondents placed behavior without calling it mental illness. Many of these types of non-mentally ill behavior are considered abnormal ("something wrong") and actionable ("something should be done"). What is interesting about these categories is that in many cases, the help-sources advocated for these behaviors are psychiatrists, the psychiatric wards of general hospitals, and to a limited extent, the provincial mental hospital, all of which we generally assume to be concerned with the treatment of mental illness.

The Nature of Being Nervous

Combining interview and observational data, let us delve further into the most prevalent of these non-mentally ill categories, "bad nerves", in an attempt to show that the distinction between normalcy and mental illness is not as clear-cut as some writers believe, but rather that the two terms occupy polar positions on a continuum of behavioral categories.

This category pops up frequently throughout the interview data

in a variety of forms: "nerves", "nervousness", "bad nerves", "weak nerves", "nervous breakdown" (for the sake of simplicity, "nerves" is used in the discussion in a manner subsuming its other terminological variations). In the interview survey, "nerves" is the single most prevalent cause given for the behavior of profile persons. The term is used, both in interview and everyday usage as a causal rather than caused phenomena, much as the term mental illness is used, allowing us little insight into what is conceived of as the cause of "nerves".

That to suffer from "nerves" is not to suffer from mental illness is abundantly clear from the interview data. Profile behavior that is considered caused by "nerves" is emphatically considered not mental illness. In addition, the profile (No. 5) which is least frequently labelled as being mentally ill is the profile most frequently defined as "nerves" (64.6 percent of all causes given for the profile person's behavior). The profile (No. 1) most frequently identified as mentally ill (and which closely approximates the folk definition derived earlier) is the profile least considered to have "nerves", (2.1 percent of all causes given).

Moreover, "just nerves" is a frequent reason given for identifying a profile person as not mentally ill. A few cases of "nerves" are labelled as being mentally ill (suggesting some overlap between the two categories) but they are all considered "not serious". The reason commonly given for labelling a "nerves" sufferer as mentally ill is the incongruity of behavior with background, rather than the more extreme attributes of violence and bizarreness which are usually attached to

that term.

"Nerves" is generally regarded as abnormal ("something wrong") and actionable ("something should be done") behavior. The most popular help-sources for the victims of "nerves" were the local doctor and non-professional community resources. Other popular resources were psychiatrists and general hospitals, more so than for profiles labelled mentally ill.[8] There was only one referral of "nerves" to the provincial mental hospital, the most popular resource for care of the mentally ill.

The reasons given for not labelling "nerves" as mental illness indicate it is considered a common affliction, and therefore not problematic. The relatively benign nature of its behavioral manifestations is obvious in that it is not the behavior of mental illness. Furthermore, the pattern of help-source referrals indicates that to a large extent, "nerves" behavior can be handled within the community. Thus we can assume that the individual with "nerves" will have a far less disruptive impact on the social situation of which he is part than an individual who displays the symptoms of being "mental". Hammer (1963: 245) states generally:

> The interrelations of social networks create a strong pressure to respond to any new situation in ways which are very similar to previously used forms of interaction, since changes in one part of a network of interactions are likely to require changes in other parts, some of which may conflict with each other. Thus,

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[8]Referrals to general hospitals, form phrasing used by interview respondents and generally in the community, are aimed specifically at the psychiatric wards of these institutions.

> despite the fact that the individual's behavior departs from what is appropriate to the situation, others in the situation tend to restructure the interaction in such a way as to enable themselves to respond with behavior appropriate to their own total situations. In doing so, they tend to make the smallest available changes and only evolve "new" behavior as external pressures and the "real" behavior of the individual forces further alteration of responses.

The designation of an individual as having "nerves" is a role-alternative which provides for a generalized reidentification of the individual short of identification as mentally ill (which entails major structural changes in the interaction fabric, expecially in the form of rejection of a group member). Categories of behavior which might otherwise be stigmatized and excluded can thus be incorporated into the institutionalized patterns of role-behavior and role-alternatives. The institutionalization of a role-alternative, such as "nerves" not only avoids the necessity of major structural changes in interactive patterns, but allows the individual to seek help and to be freed, through the sick role, of some of the behavioral expectations of a "normal" person, without fear of stigma and other negative sanctions. Institutionalization of a category such as "nerves" acts as an adaptation by both the community and the individual to the failure to fulfill all role-expectations.

Becker (1964) has adapted Hughes's (1945) formulation of "master" and "auxiliary" statuses to describe the reaction to a labelled deviant of his labellers. A person's identity as deviant is generalized to a master status which takes precedance over all other statuses possessed by the deviant individual, thus forming a basis for imputation to the deviant of other negative characteristics. The label of "mentally ill" is such a

master status, attachment of which makes inconsequential the sex, age, occupational and other auxiliary statuses of the individual. Becker's discussion, as well as those of others in the societal reaction school, ignore the possibility of the existance of auxiliary deviant status. The outport use of the behavioral category of "nerves" seems to fit exactly this conception. Being afflicted with "nerves", is considered by the outporters to be just one of a repertoire of characteristics possessed by any one individual. Rather than being merely "nervous", an individual will be described as a fisherman, father, Anglican, and possessor of "weak nerves". "Nerves" gain attention only when the individual's performance of his other roles is questioned, or in interactions focused specifically on the failing, such as between doctor and patient.

"Nerves" seem to operate as a qualifier to explain the individual's poor performance in his other roles and as such, fits the concept of disability, as used by Haber and Smith (1971) in discussing physical illness. They define disability as "the pattern of behavior emergent from incapacity; the loss of ability to perform expected role activities". Adoption of the disabled status allows both the individual and those about him to adapt, in an institutionalized manner, to his incapacity. The person identified as disabled is provided with an alternative patternof behavior as well as being excused from some performance expectations while others in his social network take up the slack.

The person disabled by "nerves" is considered "himself", but

with a common, acceptable, and relatively benign failing. On the other hand, the person who is mentally ill is "not himself"; he is a different and frightening person from what he was before being thus identified. The difference between the mentally ill and the "nervous" is as that between a master and auxiliary deviant status - a deviant trait versus a deviant role.

Speaking of "nerves" as a disability allows us to subsume under this rubric other categories of behavior, or at least category-terms which in their usage fit the disability concept, which are used in the outport setting, but appear infrequently in the interview responses. Illustrative of these categories are such terms as "retarded" and now rarely used idiomatic expressions such as "low-minded" and "unknown". All these terms vary widely, as does "nerves", in the expected behavioral manifestations to which they refer, but are alike in that they are aspects of other major roles and function as explanations of poor performance in these roles. "Retarded", for example, is a characteristic frequently attributed to welfare recipients as an explanation of their chronic unemployment and dependence on welfare.[9] Yet it is accepted that "retarded" individuals can and do often lead relatively normal lives, marrying and raising families, albeit with a performance level reduced by their disability.

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[9]It is interesting to note that while the term "retarded" is usually applied to members of the lower socio-economic group of a community, "nerves" is more characteristic of the upper group, indicating some relationship between statuses.

Implicit in the preceeding pages is the idea that the disability identity is preferred to identification as mentally ill. The interview data on "nervous conditions" and "insanity" (which we can equate with "nerves" and "mental illness") give additional support to this hypothesis that it is more desirable to be identified as having "nerves" - those with "nerves" are less dangerous, have a better chance of recovery, can be treated within the community more successfully, and are less likely to be physically and socially isolated - than to be identified as mentally ill. Adoption of the disabled adaptation by an individual is not a simple choice, but is mediated by three major considerations: availability and knowledge of an alternative to the mentally ill identity, legitimation of an individual's disabled adaptation by relevant others, and legitimation of the disabled adaptation by the appropriate professional agent or agency. The contingencies are dealt with in this order, in an attempt to illustrate the process of coming to be defined as disabled and possibly, as mentally ill.

Availability and Knowledge of Alternatives

Anthropological literature is replete with examples, such as shamanism, of how cultures evolve patterns of dealing with, normalizing, and even venerating disordered behavior without rejection of the individual. That the adaptive pattern epitomized by the "nerves" category is part of the imagery of outport culture is evident from both interview data and observational impressions. The advantages for both the individual and the community of such an adaptive pattern have already been

discussed. However, the availability to the individual of the disabled adaptation is, to a great extent, limited by his knowledge of the subtle requirements of this role. Reiss (1961), in his discussion of how young male prostitites were able to cognitively separate themselves from self and group definition as homosexual, stressed the importance of adherence to the group norms and expectations of the non-homosexual role. Individuals who did not adhere to such norms as impassivity during the homosexual encounter were defined as "queers" and ostracized from the group. Such norms and expectations govern the "bad nerves" identity as well, and individuals who lack the knowledge of the expected behavior are denied legitimation as disabled and defined as mentally ill.

The major norms pertain to the disordered behavior appropriate to each category. Any behavior that approximates sufficiently the mental illness definition is likely to be regarded as such. Another major consideration is the type of professional treatment received. The provincial mental hospital is conceived of as the place where the mentally ill are treated, while "nerves" are treated by the local doctor, bypsychiatrists, and in general hospitals.[10] Phillips (1963) reports increasing rejection, by college undergraduates, of hypothetical individuals as they were described as consulting a clergyman, a doctor, a

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[10]The preference for treatment in the psychiatric unit of the general hospital rather than in the mental hospital is functional for the disabled adaptation in that severity of illness is usually judged by the length of treatment. In 1969, the provincial average length of stay in the former type of institution was 20 days while the average length of stay in the latter was 385 days.

psychiatrist and a mental hospital. Nunnally (1961) reports a much more positive public attitude towards general hospitals than towards mental hospitals. To be successfully defined as having "nerves", the individual must use the facilities appropriate to such afflictions (therefore demonstrating that the professionals have legitimated his identity as disabled). Knowledge of the appropriate facilities, the manner of gaining access to them, and the ways to circumvent social control agents that may disrupt the process by attempting to force another form of treatment are kinds of information that are supplied by "sympathetic others", most of whom have already experienced the disabled adaption.

As Mrs. Wright, an elderly lady in Bristol Harbour put it:

> I got so bad that Bill (husband) took me to the hospital in Tickle Harbour. The doctor there wanted to put me in the Mental (provincial mental hospital) . . . so I came home again. Then Mary (next door neighbour) said she would call Dr. Smith in St. John's (psychiatrist). Mary has been going to Dr. Smith for years. She said Dr. Smith would get me in the Grace (Grace General Hospital with a 30-bed psychiatric unit). So she called Dr. Smith and he said to come in. So Bill and I went in and Dr. Smith got me in the Grace in three days and I never had to go to the Mental . . . last summer Bill got real bad, right out of himself, and the doctor here wanted him to go to the Mental for shock treatments, said he couldn't do anything more for him. But I took him into Dr. Smith and he got him the Grace right away and he had his shocks there.

Mrs. Wright's remarks are typical of a number of individuals encountered who were members of the same social network, many of whom had received their initial advice from "Mary".

Legitimation by Significant Others

Self-definition as not mentally ill, just "nervous", must be

accepted and supported by the community in general or the claim to disabled status will be rejected and the mentally ill label attached. In the case of a rejected claim, not only the community but also the individual will come to see his behavior as mental illness.

It is common for the individual to stress his self-definition as disabled at every opportunity, short of conversational impropriety. I was initially surprised, on entering the community, by the freedom and apparent lack of embarassment with which individuals disclosed and discussed past and current experiences with psychiatric treatment. It soon became apparent, however, that these discussions always revolved around "nerves" and their treatment - no person ever admitted having been treated at the provincial mental hospital.

This type of proselytizing served two functions. By speaking of their psychiatric history publicly, much in the same manner physical illness is spoken of, individuals are able to define their "problem" as nothing shameful and to define others present as sharing the same view, a technique similar to Goffman's (1963) "disclosure etiquette". Such disclosure also serves to emphasize the individual's adherence to the norms of the disabled role by contrasting their behavior with that of the mental illness stereotype and by emphasizing that they have utilized the appropriate treatment resources. As one person put it, "They wanted me in the Mental but I told them I wasn't mental. I didn't do anything like those people there, I didn't act crazy, just down. It was me nerves."

If the behavior of an individual appears sufficiently deviant to the community in general that his self-definition as disabled is not

readily accepted, others are drawn in to support or disconfirm his claim. The individual can usually rely upon his kin and other members of his social network to publicly define him as disabled. These supporters may be motivated not only by sympathy for the individual and fear of losing a group member but also by fear of the halo-effect of the mental illness stigma. Others who see the individual's behavior as problematic may lead to define him as mentally ill and to have him forced from the community. These processes are illustrated by the following case.

> Late one night in Bristol Harbour, a middle-aged bachelor, Noel Andrews, generally regarded as "a bit simple", was found attempting to break into the house of another man, George Joyce, while the owner and his family were asleep upstairs. When confronted, Noel Andrews was unable to give an adequate reason for his behavior, stating tearfully that "me nerves is acting up". Next morning, the event was the topic of most conversations. George Joyce and his wife stated vehemently that Noel Andrews was dangerously "mental", posed a threat to the whole community, and should be "taken away" as soon as possible. Noel Andrew's family, and to a limited extent, he himself, stated just as emphatically that Noel was "a bit nervous", had been drinking but was not "mental" and posed no threat to the community if left alone. Both Noel Andrews and George Joyce were members of large and influential families, each having several married brothers in the community. As it became evident that the argument as to the definition of Noel Andrews' behavior would not be resolved quickly, more and more of these kin and their friends began to support publicly one side of the argument or the other, citing incidents of Noel's past behavior to support their definition. The remainder of the community waited, unconvinced of the validity of either of the claims. After several days of stalemate, George Joyce approached both the local doctor and the RCMP constable in Tickle Harbour (who left the matter to the doctor's discretion) seeking to have Noel Andrews "taken away to the Mental". The doctor was beseiged with entreaties from both side and appeared in some doubt as to the best course to take, even asking the advice of several prominent community members, as well as the researcher. Finally the doctor declared that Noel Andrews was "a bit ill" but not seriously disturbed, and could be treated in the community by drugs. George Joyce and his group accepted with grace the rejection of of their attempt to escalate Noel Andrews' behavior to the level

> of mental illness, for to press the matter further would have been, in the community view, persecution of a sick man. George's acceptance of the doctor's definition was generally thought to be symbolized by an incident several days later when George and Noel were seen drinking beer and talking together in the "legion".

This event illustrates, amongst other things, the importance of an individual's resources in resisting definition as mentally ill. In the case just presented, the resource consisted of group support (for an alternative definition). But we could hypothesize that other resources, such as socio-economic status, would be relevant to the definitional process of community diagnosis. Rushing (1971) and Linsky (1970) found the ability to resist involuntary admission to mental hospitals to be dependent on such resources as marital status, degree of integration in the community, economic status and occupational level. A further illustration of the function of power resources in resisting the mental illness label is available when we compare the case of Noel Andrews with that of John Lee, described earlier.. Noel Andrews had power resources in his extensive and influential kin group and was able to resist, successfully, the label of mental illness. John Lee, on the other hand, was not native to Bristol Harbour and his only resources were the family of his wife. This group was alienated from him by his previous extramarital sexual behavior and stated that they were "glad to see him go". Thus, with no one to resist but the patient himself, the doctor made the decision, quickly and with few doubts, to commit John Lee to the provincial

mental hospital.[11]

It appears that an individual can be defined as mentally ill either when he has no resources with which to resist this definition or when his behavior makes the disabled adaptation untenable to even his close kin and social network.

If the threat to an individual's self-definition is less organized and pervasive than in the case of Noel Andrews, threats to this definition may be controlled by limiting contacts with individuals who might conceivably define him as mentally ill. The disabled person may seek to limit his social networks to "sympathetic others" (Goffman, 1963) who share the definition of his "problem". Of course, individuals vary in their ability to limit their contacts, according to the demands of their social roles; for example, a merchant would have greater difficulty in this regard than would a housewife.

It is characteristic of the social networks of the disabled (several distinct networks were identified in Bristol Harbour) that they will consist largely of fellow-sufferers, other persons who have assumed the disabled adaptation. Not only do these networks act as a source of cues on how to perform the disabled role but also they sustain each members' self-definition as disabled. Members of this network provide feedback on

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[11]Commitment refers to the legal process by which a physician or law enforcement agent may send an individual judged in need of psychiatric treatment, to the provincial mental hospital for such treatment, against the patient's will. Currently in Newfoundland, the signature of two physicians are necessary for commitment, but if only one physician is available, the other signature may be obtained on reaching the hospital (Mental Health Act, 1971).

each others' behavior, information on new forms of treatment (a new type of medication, for example), and a forum for discussion of symptoms, all in a setting free of the threat of exposure as being mentally ill. Members of such groups generally keep a low profile in the community, usually confining visits to other network members and only rarely attending community social events - generally "keeping to the house".[12]

Legitimation By Significant Professionals

Although an individual may have his claim to disabled status accepted and legitimated by other community members, such accreditation is worthless unless sanctioned by a professional agent, usually the local doctor. The doctor has the ability, as in the case of Noel Andrews, to legitimate the individual's claim that he is merely disabled and to reject the alternate claim that he is mentally ill. Conversely, the doctor may discredit the individual's claim by sending him to the mental hospital.

Despite mechanisms of information control, the individual is seldom able to hide the type of treatment he has received and thus the type of person he has been judged as by the professional agents. Admission to the provincial mental hospital is mostly by involuntary commitment (82.5 percent of admissions to this facility from the research area,

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[12]Some events, such as weddings of close kin and church services on religious holidays, must be attended to fulfill minimal social expectations and to avoid the impression that the individual is severely disabled.

1965-1969) which usually involves the RCMP as transportation agents. Being "taken away by the Mounties" is a particularly visible and dramatic status-passage in outport life. Unable to restrict information on the treatment they have received, individuals will attempt to influence the doctor towards diagnosis and consequent treatment that is congruent with a disabled identity. Balint (1957) discusses how a patient and his doctor may "bargain" over an acceptable diagnosis. Doctors in the research area report that patients and their families are usually quite willing to accept psychopathological interpretations of behavior and even the need for psychiatric treatment. But they strongly resist, even in the case of severe psychosis, the attachment of the label of mental illness and the suggestion of treatment at the provincial mental hospital. The doctors report that patients attempt to influence them to treat them within the community, or to refer them to treatment facilities other than the "Mental". St. John's psychiatrists have reported the same type of bargaining behavior by outport patients (personal communication).

Balint (1957) emphasizes the importance of the power resources of both doctor and patient in the bargaining process. The threat of commitment and its consequent discrediting of the individual claiming to be merely "nervous" gives the doctor considerable power in the interaction. This power induces the patient to co-operate and to accept the necessity of treatment, as long as the doctor supports the disabled adaptation.[13]

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[13]Disabled individuals frequently keep in telephone contact with a St. John's psychiatrist and after a telephone diagnosis, may be asked to travel to St. John's for treatment in a general hospital, a request quickly complied with in the interest of maintaining the disabled adaptation.

Doctors display insight into the dynamics of the disabled role in their use of the threat of commitment to curb disruptive behavior and to induce cooperation from their patients. One doctor revealed that he had approached an individual who had been drinking heavily and ordered him to stop drinking or he would be commited. Mrs. Wright reported that when she had been first offered and denied the need for psychiatric treatment, the doctor in Tickle Harbour had said: "Now Mrs. Wright, do you want the mounties to have to come to your house and take you away?"

The patient is not without some degree of influence in his relations with the doctor. It must be remembered that the doctor is not only an objective professional agent, but also a highly visible member of the outport community, participating in most aspects of community life.[14] Because of the nature of his work, the doctor is highly accessible, calling most community members by their first name, and occupies a prominent, almost ritual position, frought with rigid expectations, in community life. Like any other community member, the doctor is amenable to social pressures, as illustrated in the case of Noel Andrews. To make an unpopular diagnosis may not only damage relations with a patient but also with a neighbour.

Summary

This discussion has attempted to present a particular cultural

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[14]Outport doctors feel that they offer their patients a good range of psychotherapeutic services, from medication to discussion of personal problems, and thus prevent many from being hospitalized.

definition of disordered behavior which acts as an alternative to the mental illness designation - a means by which an individual's behavior can be cognitively separated from the group definition of mental illness. The adoption of this alternative adaptation has been traced in an effort to show how it can be disrupted and the individual redefined as mentally ill (implicit in this formulation is the assumption that an individual may not only be discredited as disabled but also not defined as mentally ill, leading to definition as a malingerer). Adoption of this alternative is yet another contingency impinging upon the process of coming to be identified as mentally ill. It is discussed later, along with the other contingencies from a broader perspective of the definitional process. At this point, it is enough to have shown the richness and complexity of the behavioral categories that lie between "normal" and "mentally ill."

CHAPTER VI

CULTURE AND ATTITUDES

Traditionally, the research orientation of social psychiatry has been to attempt to discover factors or combinations of factors in the cultural environment which produce or perpetuate various kinds of psychiatric disorders (eg. Leighton et al, 1959). This approach has never received much support from social scientists outside of the field of psychiatry. Methodologically, the practice of applying diagnostic techniques, generated in western urban settings, to the diverse cultures studied, has been questioned (Enright and Jaeckle, 1963), we well as the validity of such classification schemes in themselves (Zigler and Phillips, 1962). Conceptually, the linking of psychiatric "types" to aspects of culture entails assumptions about congitive functioning, to a degree unacceptable to most social scientists.

An interesting variation on the theme of linking mental illness to culture was provided by Cumming and Cumming (1957) in the report of their 1951 Saskatchewan study. Their project was an attempt at community mental health education, in order to remove the ignorance and fear surrounding mental illness, thus allowing for quicker recognition, earlier treatment and greater acceptance of the mentally ill (their interview data were gathered to provide a "before and after" view of the effectiveness of the educational program). However, the educational program failed; indeed, it seemed to be rejected by the community in general. The Cummings were led to speculate (in a manner similar to the "grounded" theory approach)

about the reasons for the reaction to their program. They concluded by linking, not mental illness, but attitudes towards mental illness, to the culture and social structure of the research setting. Using a functionalist framework, the Cummings developed a number of hypotheses about the relationships (in their language, the manifest and latent functions) between local culture and traditional patterns of conceiving of and reacting to the mentally ill, concluding that these patterns were an integral and functional part of community social structure.

An additional impetus for investigating the link between local culture and conceptions of mental illness is provided by the work of Sydiahia et al (1969). Comparing two different towns, each with ethnically diverse populations, on their definitions and conceptions of mental illness, they reported findings consistent with a "local culture" interpretation (differences between communities), rather than with a "traditional culture" interpretation (differences between ethnic groups) or a "societal culture" interpretation (no differences between any groups). Sociologists such as Scheff (1966) and Nunnally (1961) have considered stereotypical conceptions of mental illness largely a result of socialization through imagery transmitted by the national mass media (thus prompting studies of stereotypical material in selected sample of radio and television broadcasting, newspaper and magazine content, etc.). Although this is in many ways a cultural interpretation, it does tend to ignore the importance of many of the more localized cultural influences, being based on an implicit assumption of the homogeneity, and thus, insignificance of North American culture. The uniqueness, in North America, of the culture of the isolated coastal settlements of Newfoundland is amply illustrated by the available

ethnographic material (see Chapter II). Transmission of conceptions of mental illness from the greater North American culture is an inadequate explanation for the attitudes and practices found in the outport setting. The research area has been and, to a certain degree, still remains, isolated both physically and cognitively, from the "outside world". The media, in which the writers mentioned above place so much faith, have left the area relatively untouched.[15]

It seems appropriate to attempt to place the previously discussed conceptions of, and patterns of reacting to, mental illness in the context of the outport culture in which they occur. Again, the scope and specialized focus of this research precludes any attempt at holistic ethnography. Indeed, it results in a somewhat truncated treatment of outport social structure that will leave students of such problems unsatisfied. Utilizing the ethnographic data presented earlier and my own experiences in the research setting, several dominant themes in outport culture are contrasted in the next section with the outport imagery of mental illness.

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[15]Radio and television have only been widely available in the area since the advent of electricity in 1966. Within the past year, the Saturday edition of a St. John's newspaper has become available, but is poorly subscribed to. Outporters do not generally read for pleasure, nor for information beyond a purely utilitarian level (i.e., social welfare regulations). The general educational level is low and many of the older people are illiterate. Previously, access to St. John's and other urban centers was even more difficult than it is today and few could afford or wished to make the arduous journey.

Mental Illness and the Malevolent Stranger

Parsons (1951) tells us that the primary problem of any social system is the maintenance of order. We have come to expect, in our urban North American culture that order will be maintained for us, by officially designated agents of social control. These professional agents, we believe, will impartially enforce many of the rules and norms of our society, thereby protecting us from the consequences of both the deviant's acts, and the necessity to confront him. Such professional social control has really never been available to outport Newfoundlanders. Prior to joining Canada in 1949, law enforcement services were provided by the few, scattered Newfoundland Rangers; since 1949, police services in rural areas of the province have been provided by the RCMP, again in an inadequate fashion.[16] Whatever social control may be offered by other professional agents, such as doctors, clergymen, or welfare officers is again sporadic, and of a specialized nature. In addition, enforcement of the norms of the larger society frequently penalizes activities considered normative and acceptable in local society, leading to a fear and distrust of non-local social control agents; hunting out of season and trade with the nearby French island of St. Pierre are accepted local traditions, but dramatically at variance with the legal code.

Given the lack of, and apprehension towards, formal methods of

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[16]In the research area, one constable, stationed in Tickle Harbour, serves more than 5000 persons in ten communities, scattered over approximately 640 square miles.

social control, outport society is forced to provide means within the community of regulating and controlling the activities of its members. Firestone (1967) emphasizes this need in light of the competitive nature of many aspects of outport life, particularly in the economic sphere. He offers two possible techniques of maintaining social control in the outports: the application of sanctions in the form of culturally prescribed punishments and rewards, and the development, through socialization, of the desire by individuals to seek acceptable goals.

The nature of the outporters relation with social control agents makes the utilization of formal sanctions unlikely. But informal sanctions, which mostly consist of the withdrawal of support from cooperative economic pursuits, have declined in impact with the decline of the inshore fishing industry and the relative independence afforded by support from transfer payments and outside wage labour. More subtle sanctions, such as those which characterize face-to-face interaction, are dependent on the ability of the individual to perceive them. Overall, the application of informal sanctions is seriously limited by one of the dominant norms of outport culture, (which is discussed later), and will not concern us now.

Firestone believes that through internalization of cultural norms, outport individuals come to treat these norms as ends, rather than means. And through this internalization, social control is provided by the individual personality, in a setting where control is not easily provided by either local or "outside" society. Consonant with this situation are two dominant values of outport culture: the <u>suppression of conflict</u> and the

predictability of behavior.

Obviously, both of these values could be considered important to the successful functioning of any interactive structure or social system. But they become of crucial importance in an isolated outport society where individuals are expected to maintain self-control, rather than rely on professional agents for the maintenance and coherence of the social order. Both Firestone and Faris (1966) have stressed the negative consequences for outport social structure and itsintersecting social networks of any form of disruption, and the consequent emphasis on harmony and predictability in social relations.

Avoidance of conflict is evident in a number of aspects of outport life. According to Firestone, face-to-face interaction is characterized by the maintenance of a passive front, the acquiescence to the statements of others, and the avoidance of disagreement, argument, and overt emotional expression. Interpersonal conflicts, when they arise, are usually either ignored or settled amicably; there is little or no recourse to outside social control agents for settling disputes. Although there is a courtroom in Bristol Harbour and a magistrate is available when needed, legal services are rarely used. In recent memory, the only court cases have been those of local residents apprehended by the RCMP or other "outside" professional agents. The only recent case of legal conflict between community members (a merchant prosecuting a long-standing debter) was kept as non-public as possible through the merchant's use of his influence with the magistrate to have a private (no spectators) hearing. The matter of damage inflicted on cars by rock-throwing children is

seldom brought to their parents because, as one person stated, "he might get his back up". The embezzlement of funds from a men's social club by several of the members was not pursued, although identity of the culprits was fairly certain and the sum exceeded one thousand dollars. The reason given for not confronting the thieves was that "it might cause a piece of business (a fight) and break up the club".

Conflict[17], and its attendant threat of danger and violence, is closely linked with the concept of unpredictability. To be unable to predict an individual's behavior is to be unable to assess his propensity to threaten one's life and person. In a setting where the undesirable consequences of unpredictable behavior cannot be prevented by the social control agents, the expectation that an individual will act in a normative and predictable manner gains crucial importance. For an individual to act in a deviant manner in one situation indicates that he may act in a deviant manner in other social situations, and that his fellow social actors do not possess enough knowledge of him to predict when and how he will act this way. This type of behavior also indicates that the deviant is a person at least partially outside of the control of cultural norms.

In outport life, the epitome of unpredictability and thus, threat, is the stranger. Although treated with overt hospitality and warmth[18],

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[17]The emphasis on the suppression of conflict limits the range and application of informal community sanctions, for the application of sanctions is usually, or can become, a conflict laden situation.

[18]Firestone (1969) believes that this hospitality serves two funcions: to extract information from the stranger (and thus lower his unpredictability), and to establish positive relations with a potential threat.

the stranger is covertly feared, or at least, is the focus of suspicion and apprehension. A stranger is someone about whom the community knows little or nothing; his origin, what type of person he is, or his reason for being in the community. Community residents depend upon each other to hold the same norms, attitudes, and values, thus insuring the predictability, the continuity, and the coherence of social interaction. In the case of the stranger, the outport community has no knowledge of the degree to which he shares or fails to share their values. Between the stranger and the native resident on the continuumof predictability lies the outsider, a person (usually a professional who has resided in the community for some time, but was not born in it) of whom much is known, thus lowering his perceived unpredictability and threat. Also, the outsider has had a chance to adopt, and to publicly display his willingness to adopt, local cultural norms. The outsider is still suspect, however, because of his non-local origin, implying that he can never completely share local norms, nor be completely "known" locally.

During my stay in Bristol Harbour, I was struck on several occasions by the differential reaction to outsiders and to native residents who violated the same norms, in most cases, sexual. The reaction to the deviance of outsiders was much more intense than to the deviance of native residents. While native sexual deviators were virtually ignored by the community in general, outsiders in the same category were the subject of much gossip, imputation of other deviant characteristics, social and physical exclusion from social networks and community events, and even talk of exclusion from the community itself. Deviance on the part of the outsider, given the

relative lack of information about him, and thus his greater unpredictability, has much more serious implications than the deviance of the native resident of whom much more is known. Also, not being an intergral part of the community structure, the outsider may be sanctioned without the disruptive consequences associated with sanctioning a fellow native resident.

Clearly, there is a parallel between the dominant themes of outport culture just discussed - conflict supression and predictability - and the major themes running through the outport definition of mental illness. Faris (1969: 134) describes the outport view of the stranger as "...unpredictable, unreliable, not to be trusted, deviant, and...potentially dangerous and malevolent", a description that closely approximates the outport definition of mentally ill. In the outport view, as previously discussed, to be mentally ill is to be unpredictable, bizarre, and to pose a threat to both social interaction and physical well-being.[19]

As illustrated in the previous chapter, not all abnormal behavior in the outport is labelled as mental illness. Persons disabled by "nerves" but whose behavior is still, to a large extent, predictable from their other statuses, are not so labelled. The mentally ill are those individuals whose behavior is unpredictable, and thus pose a threat. In other words, individuals whose behavior fits the mental illness definition have rejected two of the cardinal values of outport society; the avoidance of

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[19]The mentally ill individual, in the community view, can be symbolically equated to the stranger, for the mentally ill are "not themselves," they are new persons of whom little or nothing is known, and little or nothing is predictable.

conflict and the predictability of behavior. Given that the lay definition of mental illness is commonly held, persons to whom this definition applies constitute a serious disruptive element in outport society. In the absence of adequate social control resources within the community, this disruptive element must be removed to a setting, such as the provincial mental hospital, where control can be achieved.

Perceived Threat

Unpredictability and potential for conflict can be subsumed under the term "threat", for both concepts imply possible negative consequences for other community members. The judgement of the mental illness of an individual is determined by the degree to which he is perceived as a threat to others. Conceptualization of the lay definition of mental illness in terms of perceived threat emphasizes the social nature of this definition, in contrast to the psychological nature of the psychiatric definition.

The orientation to behavior exhibited by medical and psychiatric professionals is basically one of searching for signs or symptoms of an underlying mental-emotional disorder. The basis of psychiatric diagnostic categories is the implication of an individual's behavior for his internal psychic state, rather than for his relations with his fellow social actors. Behavior in the "psychological" view, acts merely as a sign, of the existance and of the nature of the cognitive disorder.

Lay definitions, of the outporters on the other hand, are more concerned with the implications of an individual's behavior for the social

situation of which he is part. Mental illness is that behavior which is beyond any means of community control, which seriously threatens not only the physical well-being but also the successful functioning of the community, and which must be eliminated for the protection of all. In other words, identification of an individual as mentally ill is a judgement of his social nature, of his potential threat to his fellow social actors, rather than an assesment of the internal functioning of his mental processes.

Support for the notion that the lay label of mentally ill is a social rather than a psychiatric judgement is provided by other sociological research. Phillips (1963) implies that despite the influence of other factors on the rejection (by a sample of college undergraduates), of a number of hypothetical individuals, the crucial factor in determining rejection is perceived potential disruptiveness and violence. Bord (1971) compared samples of varying psychiatric "sophistication" and found that despite increasing sophistication in this area, rejection of hypothetical individuals was based on perceived unpredictability and threat rather than psychiatric seriousness. Conover and Whitmer (1959) report the same conclusions.

Given their different orientations to mental illness, it is not surprising that lay populations do not agree with psychiatrists as to what constitutes mental illness, (as illustrated in Chapter III). We can also see why it is difficult to describe the kinds of behavior which fall into the various categories such as "nerves" or mental illness. It is not these behaviors <u>per se</u> which determine their categorization, but

rather their social implications, the degree to which they are perceived as disruptive and posing a threat. Thus we would find in Bristol Harbour, cases of relatively severe psychosis (in the doctor's view) described as "nerves" and cases of neurotic depression (again in the professional view) committed to the provincial mental hospital.

Folk Psychiatry

It is necessary in the light of the previous, truncated view of outport culture, to dispel any possible illusions of a tightly constrained, puritanical society. Conflicting and unpredictable behavior does occur in outport life. However, such deviation is usually displayed only at appropriate and culturally acceptable times and places. As Faris (1966) has illustrated these occasions of sanctioned deviation, usually weddings or other social events or "times", provide a relaxation of the usual prohibitions against heavy drinking, sexual license, and physical conflict - in fact such behavior is almost an expected part of such occasions.[20] In short, these are occasions during which individuals may be predictably unpredictable, social repercussion being nullified by explaining the behavior as the result of drunkeness, and thus beyond the individual's control.[21]

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[20]A similar function may be served by the semi-annual trip to St. John's.

[21]If it is known that an individual is especially disruptive under such circumstances, subtle efforts may be made to control or to accomodate his behaviour, such as limiting his access to liquor or removing breakable valuables. In general, however, the emphasis is on accepting whatever behaviour may arise.

Attendance at such an event is one of a number of community help-sources (referred to in Chapter III as non-professional community resources) to which individuals are referred in an effort to modify their abnormal behavior. These non-professional attempts at behavior modification, usually recommended for minimally disruptive individuals, seem to stem from a sort of folk psychiatry. However, the use of the term psychiatry, in any sense, implies a theory of the mind, in this case, a folk psychology. Lack of data in this aspect of outport life precludes a comprehensive discussion of folk psychology, and thus, folk psychiatry, yet some aspects of the community "treatment" of disordered behavior should be mentioned.

Anthony Wallace (1961) has provided us with a convenient typology of the strategies of folk psychiatry by which cultures attempt to alleviate emotional disturbance amongst their members: catharthic strategies, projective strategies, and control strategies. Catharthic strategies are the opportunities for expression of emotion and hostility; they are seen in the outport "time" or occasion of sanctioned deviance. A less dramatic and public catharthic experience is provided by confession, an opportunity to "talk to someone about their problems" (usually close kin).

Projective strategies refer to the expression of emotional disorder in other, more socially acceptable ways, such as through symptoms of physical disorder. Local doctors claim that many of their patients suffer from psychosomatic complaints (more so than in their urban practices). Indeed, physical illness is a major topic of outport conversation and seems at least to provide a means for the expression of discomfort and discontent.

Control strategies refer to the exhortation of individuals to control

their problems by a feat of will or self-reliance; "tell him to get hold of himself". Control strategies seem to be the most prevalent non-professional method of behavior modification. They frequently involve a group effort. Thus there is constant urging to self-reliance on the part of the individual, which enhances his feelings of his importance to the group.

No doubt, further study of the medical folkways of outport peoples would tell us more about the folk psychiatry that exists there. For the time being, lack of data forces us to leave this fascinating subject.

CHAPTER VII

SUMMARY: THE SOCIAL NATURE OF MENTAL ILLNESS

This report has not been concerned with the clinical question of how individuals become mentally ill nor the epidemiological question of the amount of mental illness within social sub-groups (indeed, it seems that the hospital admission data normally used in such research is incapable of informing us on these issues). Instead, our interest has been in examining the response to mental disorder within a certain social group.

An integral part of the societal reaction is the conceptions held, by laymen, of what constitutes a particular kind of social deviance. The outport definition of mental illness can be described at three levels. Behaviorially, the actions of the mentally ill are bizarre, violent, suicidal, unpredictable and exhibit a loss of contact with reality. Normatively, the mentally ill are violaters of norms highly valued in outport society, such as conflict suppression and the predictability of behavior, as well as violaters of less significant norms. Socially, the mentally ill disrupt and threaten the coherence of social interaction.

The labelling of actual incidents of disordered behavior as indicative of mental illness illustrates the essential fluidity of lay conceptions of this type. We have discussed, in previous chapters, a number of social contingencies that influence not only the process of defining the mentally ill but also the very lay conceptions of deviant behavior. In conjunction with Figure III, the process of coming to be defined as mentally ill is discussed, thus enabling us to illustrate the definitional

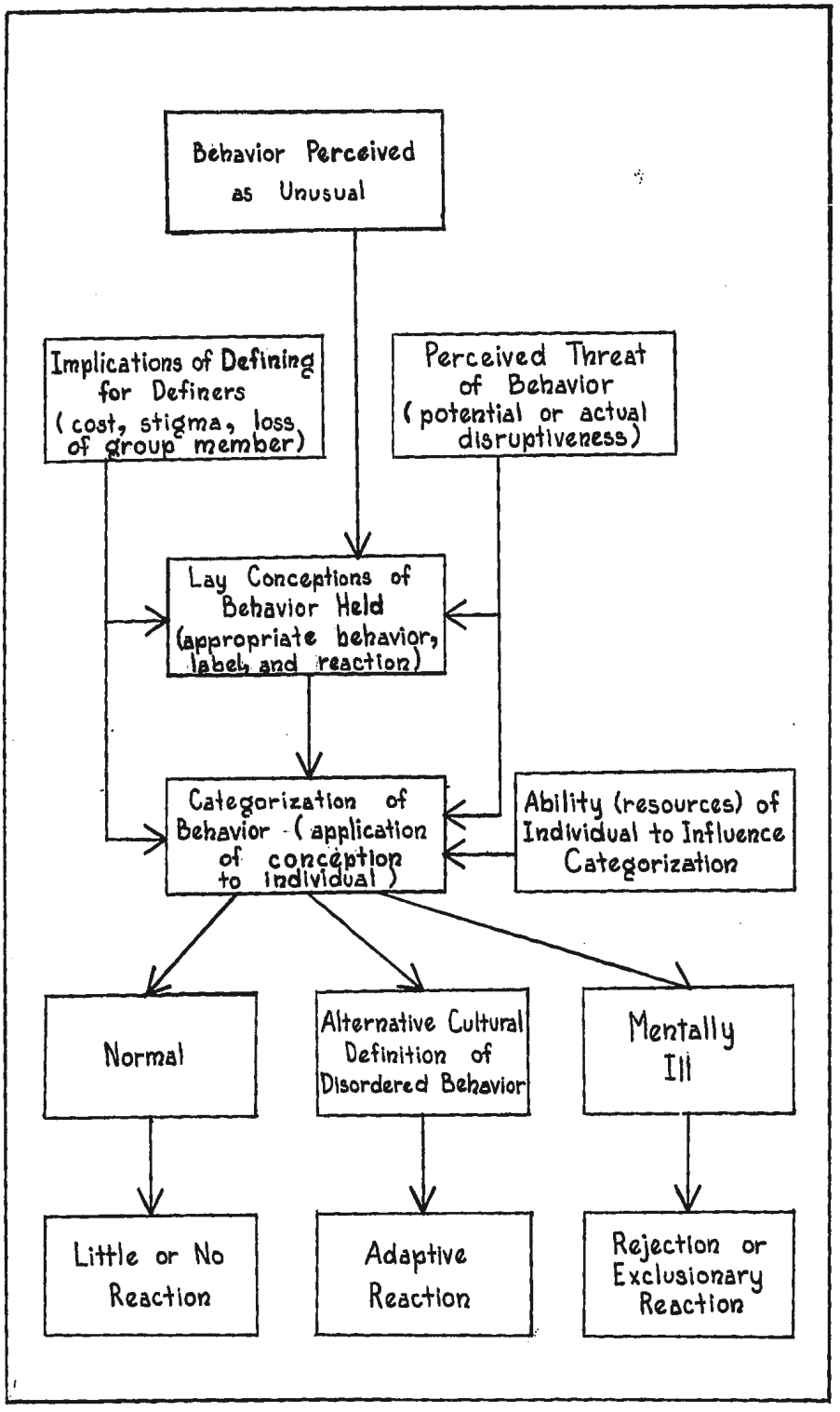

Figure III. Schematic View of the Definitional Process.

process while integrating the contingencies discussed previously. Despite its generation from outport data, the process is discussed in general terms, to maximize its potential for generalization to other settings.

Identification as Mentally Ill

We are concerned here with behavior which is conceived as unusual for the individual but which does not fall into the more convenient categories of deviant behavior, such as crime or homosexuality. It is, in essence, abnormal behavior for which there is no ready label: what Scheff (1966) refers to as "residual deviance". We may assume that such behavior occurs and will be often noted by the individual's group as unusual.

We may also assume that any society will have one or more categories into which to place such behavior. Associated with these categories or conceptions is a prescription of the kinds of behavior thought appropriate to the category, a label by which to term the behavior, and a prescription of the behavior to be exhibited towards an individual to whom the label has been attached (appropriate reaction). These conceptions are part of the culture of the social group in which they occur. They constitute a social reality, learned through socialization, that is used to understand individuals whose behavior is deviant.

These lay conceptions are to a certain extent, the function of social contingencies. The behavior thought to be appropriate to the different categories will depend upon the threat the behavior is perceived to pose for individual safety and community social control. Violent and

disruptive behavior is conceived as appropriate to the mentally ill. Less threatening and unpredictable behavior is part of the definition of "bad nerves" or other labels of disability. Behavior of an easily explainable and non-threatening nature is normalized.

The conceptions held within a group will also be mitigated by the implications for the group of defining an individual in a certain way. Considerations, such as the cost of and distance to the professional services, which constitute part of the appropriate societal reaction to a definitional category, will influence the types of behavior thought to fall into that category. Groups for whom the utilization of medical resources is relatively difficult and costly will have a narrower view of the types of behavior thought to be appropriate to definitions which entail the use of such services.

Another contingency of lay conceptions of mental illness which has been suggested as being relevant (e.g., Cumming and Cumming, 1957) is the degree to which behavior is perceived as under the individual's control - in other words, if the behavior is purposive or not. Unfortunately, the examination of this contingency in the present study proved inconclusive and thus is excluded from the schematic representation (Figure III) of the definitional process.

The nature of the set of cultural conceptions of abnormal behavior found in the research setting has been described. The next step in the definitional process, after an individual has been noted as exhibiting unusual behavior, is to attach the appropriate definition to the behavior, and thus to the individual. This categorization not only enables the

categorizing individual and group to "explain" the deviant's behavior (terms such as "nerves" and "mental" are used as explanations of behavior) but also delineates the culturally prescribed manner of responding to the individual in question.

Like the conceptions of mental illness, identification or categorization of a particular individual is also influenced by a number of social contingencies. Despite the fact that an individual may fit the definition of mentally ill or other identities, attaching the label may be influenced by consideration of the implications for others (in terms of cost, loss of a group member, or the "halo" effect of stigma) of labelling. The perceived threat of the individual's behavior is also a factor in his categorization. For example, behavior usually part of the conception of "nerves" and thus relatively unthreatening, may be considered extremely threatening and thus defined as mental illness if the individual who exhibits the behavior occupies a particularly critical position (i.e. - the outport merchant) in the social system.

Categorization is also contingent upon the individual's ability to influence the definition of his own behavior. Persons with extensive resources, such as group support or social status, may be able to resist the imputation of mental illness and instead claim, and be awarded, definition as normal or merely disabled.

With categorization, the individual is defined as being normal, mentally ill, or, if alternative cultural definitions such as disability are available, somewhere in between these polar states. It only remains

for the reaction appropriate to the individual's definitional category to take place. Those judged as normal will have the unusual aspects of their behavior ignored, and will be treated in much the same manner as they always were. Those judged to be disabled will have their disability adapted to by their social groups. Those judged to be mentally ill will most likely be rejected and excluded, either physically from the community or symbolically from interaction within it. The label which has been applied to an individual, and its stereotyped beliefs about his behavior, justify the manner in which he is treated.

In summary, the societal reaction to mental illness is not simply an objective judgement, by the community, of the severity of an individual's "illness". Rather it is the result of the individual's behavior in interaction with the social setting in which it takes place. The societal reaction depends upon the variety and nature of the cultural definitions of abnormal behavior, the perceived threat of the behavior displayed, the implications for others of defining the individual as mentally ill, and the ability of the individual to influence the definition of his own behavior.

Tentative Hypotheses

A number of hypothetical propositions about the nature of the societal reaction to mental illness have been both implicit and explicit in the preceding chapters. Despite the exploratory nature of this study, the small size of the interview sample and sub-samples, and the concentration of participant observation in one community, it seems appropriate

to offer these hypotheses in a generalized form as if they held for a variety of settings. Of course more controlled research will be needed to determine if they actually do.

Identification of an individual as mentally ill, by laymen, is a judgement of the social nature of their behavior. Individuals are perceived as mentally ill according to the unpredictability, disruptiveness, and general threat of their behavior for the personal safety and successful social interaction of their fellow community members.

The individual's social group tends to normalize behavior which is not perceived as threatening. Behavior is normalized by explaining it as the result of acceptable, conventional situational forces such as moods or habits. Behavior which cannot be explained in this manner may be considered mental illness.

Cultural conceptions or definitions of mental illness and other forms of disordered behavior arise as an expression of group values in certain problematic situations. These conceptions include prescriptions of expected behavior e.g., violence, bizarreness, a label for the behavior (mental illness), and a prescription of the appropriate ways of reacting to the labelled individual e.g., (removal to the provincial mental hospital).

Labelling an individual mentally ill leads others to impute to him the characteristics of this identity. Not only is he reacted to as a person who is violent and unpredictable, but incidents in his past behavior are selected to illustrate the appropriateness of the label for him.

There are culturally prescribed ways of reacting to mental illness and other unusual behavior, which include various degrees of professional and non-professional involvement. Those judged mentally ill usually are removed from the community, to the control of medical and psychiatric professionals.

The form of the societal reaction to a deviant is influenced by the conceptions held of his nature. If the mentally ill are regarded as relatively incurable and permanently threatening, then they are treated with fear and suspicion. If a sufferer of "nerves" is seen as relatively harmless, then he is treated with acceptance and accomodation.

There may exist a range of cultural alternative conceptions of deviant behavior between the polar concepts of normal and mental ill. Terms such as "nervous" or "retarded" may be used to denote individuals whose behavior is unusual but still predictable from their other, conventional identities.

Conceptions of the behavioral manifestations of mental illness and other categories of deviant behavior are not rigidly fixed but may be modified by various social contingencies. Relevant factors include the availability and cost of professional help-sources, and the perceived threat of different kinds of behavior.

Identification of an individual as mentally ill (the application of conceptions to individuals) is also influenced by social contingencies. Amongst these factors are the availability of professional services, the perceived threat of the behavior exhibited, and the ability of the individual to influence his own identification.

The utilization of medical, psychiatric, and other professional resources is dependent, to a degree, upon their availability. Groups distant from such facilities, or of a lesser ability to pay for them, are less prone to use them.

Conceptions of mental illness and other types of deviant behavior are influenced by the implications of attaching these labels. Differentials in the availability of professional resources influence definitions of the type of behavior thought appropriate to their treatment. Such factors will determine which individuals and which types of individuals will be brought to professional attention.

Identifying differences in the incidence of mental illness on the basis of psychiatric hospital admission rates only, is an inadequate data base. Investigations into such phenomenonas urban-rural differences in the rate of treated mental illness, must consider the social as well as the pathogenic factors operating in any setting. Indeed, admission rates appear to be useful in illustrating the influence of such social factors as the accessibility of medical services.

The Societal Reaction Perspective

This study has been concerned with the nature of the societal reaction of non-professionals to the phenomena of mental illness. It is appropriate, before closing, to briefly assess the validity of such a research focus, and to consider any implications of the study for the societal reaction school of deviance theory.

The laymen's conceptions of mental illness discussed in this study

have proven to be an extremely fluid and contingent dimension. The outport societal reaction has been shown to be an integral part of the characteristics and structure of the social setting. Most importantly, laymen not only differ from psychiatrists in their view of mental illness but moreover the laymen's conceptions seem to determine which individuals will come to the attention of the professionals and thus be officially designated as mentally ill. There is an indication that community societal reaction can be used to explain differing rates of psychiatric hospitalization.

As for the finer points of societal reaction, or "labelling" theory, they have been supported in a number of ways. Implicit in the entire discussion is the interactive nature of the process of coming to be defined as mentally ill. The imputative nature of the mental illness label is also evident, as well as the encompassing nature of the deviant label or "master status". Finally, and perhaps most significantly, the study has shown that mental illness is not a characteristic inherent in an act or number of acts but is, rather, a label bestowed upon them.

A Final Note

A research report of this type, because of its exploratory nature and its concern with a particular phenomena, should end on a cautionary note. It is not meant to imply that there is no such thing as mental illness as psychiatrists view it nor that psychiatric diagnostic methods are completely without validity - such conclusions are beyond the scope

of this research and perhaps unrealistic in any case. I have not shown, nor attempted to show, that particular types of social situations help generate mental disorder, not that such behavior is completely a product of societal reaction. There is much of merit in the theories of psychiatry and social psychiatry. But I do believe, and hopefully this study has shown, that any theory of mental illness, or of social deviance, must take into account the nature and variety of the conceptions of behavior held within a community or society. Failure to do this is to ignore a rich and significant aspect of our understanding of mental illness.

APPENDIX I

The Interview Format

INTERVIEW SCHEDULE

1. A. What would you say is the most serious disease today? (I mean what illness would be the worst one for a person to have?)

   B. Why is (name of illness) the most serious one?

2. Of course, everybody hears a good deal about physical illness and disease, but now, what about the ones we call mental or nervous illness? When you hear someone say that a person is "mentally-ill," what does that mean to you? (Probe: How would you describe a person who is mentally ill? What do you think a mentally ill person is like? What does a person like that do, that tells you he is mentally-ill? How does a person like this act?)

3. Now I'd like to describe a certain kind of imaginary person and ask you a few questions about your opinion of him.....lets call this imaginary man Frank Jones. He is a man who is very suspicious; he doesn't trust anybody and he's sure that everybody is against hom. Sometimes he thinks that people he sees on the road are talking about him or following him around. A couple of times, now, he has beaten up men who didn't even know him, because he thought they were plotting against him. The other night, he began to curse his wife terribly; then he hit her and threatened to kill her, because, he said, she was working against him, too, just like everyone else.

Would you say there is anything wrong with this person, or not?

Something wrong .....,.....
Nothing wrong .....
Don't know ....

Spontaneous comment:

A What do you think makes him act this way: (Probes: What's causing him to act like this? What happened to make him like this?

B Do you think anything should be done about this person?

Yes .....
No .....
Don't know .....

C *If "yes"
What should be done? (Probes: How can this person be halped? Who should help? If doctor -- what kind of doctor. If hospital-- what hospital.)

C Would you say this man--Frank Jones--has some kind of mental illness or not?

Has .....
Has not .....
Depends .....
Don't know .....

(1) Why do you say that he has (does not have) a mental illness?

*If answer to D is "Has,"
(2) Would you say that the mental illness he has is a serious one or not?

Serious .....
Not serious .....
Depends .....
Don't know .....

(a) (If "Serious", "Not serious" or "Depends") Why do you say it is (is not) serious?

4. Now here's an imaginary young woman in her twenties, lets call her Betty Smith. She doesn't seem to want to do anything except sit around. She is a very quiet girl, she doesn't talk much to anyone--even her own family, and she acts like she is afraid of people, especially young men her own age. She won't go out with anyone and whenever anyone comes to visit her family, she stays in her room until they leave. She just stays by herself and daydreams all the time, and shows no interest in anything or anybody.

Would you say that there is anything wrong with this woman, or not?

Something wrong .....
Nothing wrong .....
Don't know .....

Spontaneous comment:

A What do you think makes her act this way? (Probes: What's causing her to act like this? What happened to make her like this)?

B Do you think anything should be done about this person?

Yes .....
No .....
Don't know .....

*If "Yes"

C What should be done? (Probes: How can this person be helped?

Who should help? If doctor - what kind of doctor? If hospital - what kind of hospital)?

D Would you say this woman--Betty Smith--has some kind of mental illness or not?

Has .....
Has not .....
Depends .....
Don't know .....

(1) Why do you say that she has (does not have) a mental illness?

*If answer to D is "Has,"

(2) Would you say that the mental illness she has is a serious one or not?

Serious .....
Not serious .....
Depends .....
Don't know .....

(a) (If "Serious," "Not serious" or "Depends") why do you say it is (is not) serious?

5. Here's another kind of man; we can call him George Brown. He has a good job and is doing pretty well at it. Most of the time he gets along alright with people, but he is always very touchy and he always loses his temper quickly, if things aren't going his way, or if people find fault with him. He worries a lot about little things and he seems to be moody and unhappy all the time. Everything is going along all right for him, but he can't sleep nights, brooding about the past and worrying about things that might go wrong.

Would you say there is anything wrong with this person, or not?

Something wrong .....
Nothing wrong .....
Don't know .....

Spontaneous Comment

C *If "Yes"

What should be done? (Probes: How can this person be helped? Who should help? If doctor - what kind of doctor? If hospital - what hospital?)

D Would you say this man--George Brown--has some kind of mental illness or not?

Has .....
Has not .....
Depends .....
Don't know .....

(1) Why do you say that he has (does not have) a mental illness?

*If answer to D is "Has,"

(2) Would you say that the mental illness he has is a serious one or not?

Serious .....
Not serious .....
Depends .....
Don't know .....

(a) (If "Serious," "Not serious" or "Depends") Why do you say it is (is not) serious?

6. How about this imaginary man, Bill Williams. He has had several good jobs but has lost them because he drinks so much. Whenever he has money in his pocket, he goes on a spree; he stays out until all hours drinking and never seems to care what happens to his wife and family. Sometimes he feels very bad about the way he treats his family; he begs his wife to forgive him and promises to stop drinking, but he always goes off again.

Would you say there is anything wrong with this person, or not?

Something wrong .....
Nothing wrong .....
Don't know .....

Spontaneous Comment:

A What do you think makes him act this way? (Probes: What's causing him to act like this? What happened to make him like this)?

B Do you think anything should be done about this person?

Yes .....
No .....
Don't know .....

C *If "Yes"

What should be done? (Probes: How can this person be helped? Who should help? If doctor - what kind of doctor? If hospital - what hospital)?

D Would you say this man--Bill Williams--has some kind of mental illness or not?

Has .....
Has not .....
Depends .....
Don't know .....

(1) Why do you say that he has (does not have) a mental illness?

*If answer to D is "Has,"

(2) Would you say that the mental illness he has is a serious one or not?

Serious .....
Not serious .....
Depends .....
Don't know .....

(a) (If "Serious," "Not serious" or "Depends") Why do you say it is (is not) serious?

7. Here's another imaginary girl; let's call her Mary White. She seems happy and cheerful; she's pretty, has a good enough job, and is engaged to marry a nice young man. She has loads of friends; everybody likes her and she's always busy and active. However, she just can't leave the house without going back to see whether she locked the door. And one other thing about her; she's afraid to ride in a car; she just won't go any place where she'd have to ride in a car to get there.

Would you say there is anything wrong with this person, or not?

Something wrong .....
Nothing wrong .....
Don't know .....

Spontaneous Comment:

A What do you think makes her act this way? (Probes: What's causing her to act like this? What happened to make her like this)?

B Do you think anything should be done about this person?

Yes .....
No .....
Don't know .....

C *If "Yes"

What should be done? (Probes: How can this person be helped? Who should help? If doctor - what kind of doctor? If hospital - what hospital)?

D Would you say this girl--Mary White--has some kind of mental illness or not?

Has .....
Has not .....
Depends .....
Don't know .....

(1) Why do you say that she has (does not have) a mental illness?

*If answer to D is "Has,"

(2) Would you say that the mental illness she has is a serious one or not?

Serious .....
Not serious .....
Depends .....
Don't know .....

(a) (If "Serious," "Not serious" or "Depends") Why do you say it is (is not) serious?

8. Now the last imaginary person I'd like to describe is a twelve year old boy--Bobby Grey. He's bright enough and in good health, and he comes from a comfortable home. But his father and mother have found out that he's been telling lies for a long time now. He's been stealing things from stores and taking money from his mother's purse, and he has been staying away from school whenever he can. His parents are very upset about the way he acts, but he pays no attention to them.

Would you say there is anything wrong with this person, or not?

Something wrong .....
Nothing wrong .....
Don't know .....

Spontaneous Comment:

A What do you think makes him act this way? (Probes: What's causing him to act like this? What happened to make him like this)?

B Do you think anything should be done about this person?

Yes .....
No .....
Don't know .....

C *If "Yes"

What should be done? (Probes: How can this person be helped? Who should help? If doctor - what kind of doctor? If hospital - what hospital)?

D Would you say this boy--Bobby Grey--has some kind of mental illness or not?

Has .....
Has not .....
Depends .....
Don't know .....

(1) Why do you say that he has (does not have) a mental illness.

*If answer to D is "Has,"

(2) Would you say that the mental illness he has is a serious one or not?

Serious .....
Not serious .....
Depends .....
Don't know .....

(a) (If "Serious," "Not Serious" or "Depends") Why do you say it is (is not) serious?

9. Well, we've been talking about different kinds of people and what makes them act the way they do...Now let's talk about people who go out of their minds, go insane...What causes people to go out of their minds? (What else could cause people to go insane?)

10. Now, how about people who aren't out of their minds, but do have emotional problems or nervous conditions...Would you say that these less severe nervous conditions have the same causes as insanity or not?

Same as insanity .....
Different .....
Some same, some different .....
Don't know .....

A (IF "DIFFERENT" OR "SOME SAME, SOME DIFFERENT") What would you say causes people to get into these less nervous conditions? (Can you think of anything else which would cause nervous conditions in people?)

11. Now, talking about people who have these nervous conditions, without being out of their minds .....

Do you think people who have these less severe nervous conditions

can get over them, or not?

Can .....
Cannot .....
Some can, some cannot .....
Don't know .....

A (IF "CAN" OR "SOME CAN") Can they get over these nervous conditions by themselves or do they need help to get over them?

By themselves .....
Need help .....
Both .....
Depends .....
Don't know .....

(1) What can they do by themselves to get better? (Anything else?)

12. Is there anything that can be done to keep a person from getting these nervous conditions?

Yes .....
No .....
Depends .....
Don't know .....

*IF "YES," ASK A.
**IF "NO," ASK B.
***IF "DEPENDS," ASK A AND B.

A What can be done? (Anything else)? (IF "DOCTOR," PROBE: Any special kind of doctor)?

B Why not (Why can't anything be done)?

13. A What do you suppose you would do if you were worried about someone in your family (or someone close to you) who was not acting like himself? (I mean, suppose someone in your family started acting like some of the people we have been talking about, what would you do about it)? (IF "DOCTOR," PROBE: Any special kind of doctor)?

B (IF ANY ANSWER OTHER THAN "SEEK PSYCHIATRIC ADVICE") Suppose that didn't work...what would you do next? (IF "DOCTOR," PROBE: Any special kind of doctor)?

14. Now let's take a person who loses his mind...Once this person goes out of his mind, is there anything that can be done to help him get better again?

Yes .....
No .....
Depends .....
Don't know .....

*IF "YES," ASK A.
**IF "NO," ASK B.
***IF "DEPENDS," ASK A AND B.

A What can be done for him? (Anything else)? (IF "DOCTOR," PROBE: Any special kind of doctor)?

B. Why not (Why can't anything be done)?

15. Do you think a person who goes out of his mind should be placed in a mental hospital (asylum), or not?

Should .....
Should not .....
Depends .....
Don't know .....

*(1) (IF "SHOULD," "SHOULD NOT," OR "DEPENDS") Why do you think he should (should not) be placed in a mental hospital?

16. Do you think anything can be done beforehand to keep a person from losing his mind?

Yes .....
No .....
Depends .....
Don't know .....

*If answer "Yes"

A What could be done?

*If answer "No"

B Why not?

17. Do you think that most of the people who are mentally ill stay that way or do most of them get well again?

Most stay that way .....
About half and half .....
Most get well .....
Don't know .....

*A (IF "MOST STAY THAT WAY" OR "ABOUT HALF AND HALF") Why is it that so many of them don't get well?

18. In general, would you say that a person who gets mentally ill can get completely well again, or would he always show some signs of having been mentally ill once?

Can get completely well .....
Always show some signs .....
Depends .....
Don't know .....

*A (IF "ARE") What makes it dangerous to be around them?

20. Do you think it might do people harm in any (other) way to be around someone who is mentally ill.

Yes .....
No .....
Depends .....
Don't know .....

*A (IF "YES" OR "DEPENDS") How might it be harmful?

21. If you found out that someone you knew who seemed all right now had been in a mental hospital once, do you think you'd feel any different about being around this person?

Would feel different .....
No Different .....
Depends .....
Don't know .....

IF "WOULD FEEL DIFFERENT," ASK A.
IF "NO DIFFERENT" OR "DON'T KNOW" ASK B.
IF "DEPENDS," ASK A AND B.

A How do you think you'd feel about being around him (her)?

B Do you think you would treat a person who had once been in a mental hospital any differently than you treat other people? (How would you treat him (her)?

22. Do you think that most people here would feel the same way that you do about being around a person who had once been in a mental hospital (asylum), or not?

Same .....
Different .....
Don't know .....

A (IF "DIFFERENT") How do you think most people would feel about being around this person?

23. Of course, you know that sometimes people who have mental illnesses or nervous problems go to psychiatrists (doctors who specialize in treating mental illness and nervous conditions) for help...

As you see it, how serious a problem should a person have before he goes to se a psychiatrist? (Why)?

24. Have you known any (other) people who you think would be helped if they'd see a doctor about a mental problem?

Yes .....
No .....
Don't know .....

22. Do you think that most people here would feel the same way that you do about being around a person who had once been in a mental hospital (asylum), or not?

Same .....
Different .....
Don't Know .....

A (IF "DIFFERENT") How do you think most people would feel about being around this person?

23. Of course, you know that sometimes people who have mental illnesses or nervous problems go to psychiatrists (doctors who specialize in treating mental illness and nervous conditions) for help ...

As you see it, how serious a problem should a person have before he goes to see a psychiatrist? (Why?)

24. Have you known any (other) people who you think would be helped if they'd see a doctor about a mental problem?

Yes .....
No .....
Don't Know .....

REFERENCES

Avnet, Helen H.
1962 Psychiatric Insurance. New York: Group Health Insurance Inc.

Balint, Michael
1957 The Doctor, His Patient, and the Illness. New York: International Universities Press.

Becker, Howard S.
1964 Outsiders. New York: Free Press

Bord, R. J.
1971 "Rejection of the mentally ill: continuities and further developments." Social Problems 18 (spring):496-509.

Buck, C. W., Wanklin, J. M., Fleming, D. F., and G. E. Hobbs.
1955a "An analysis of regional differences in mental illness." Journal of Nervous and Mental Diseases 122:73-79.
1955b "A symptom analysis of rural-urban differences in first admission rates." Journal of Nervous and Mental Diseases 122:80-82.

Chiaramonte, Louis J.
1971 Craftsmen-Client Contracts: Interpersonal Relations in a Newfoundland Fishing Community. St. John's: Institute of Social and Economic Research, Memorial University of Newfoundland.

Clausen, A. and M. Yarrow
1955 "Paths to the mental hospital." Journal of Social Issues 11 (No. 4):25-32.

Cohen, Albert K.
1955 Delinquent Boys: The Culture of the Gang. New York: The Free Press of Glencoe.

Cohen, B. M., Tietze, C. and E. Greene
1939 "Statistical contributions from the mental hygiene study of the eastern health district of Baltimore." Human Biology 11:485-92.

Conner, D. M. and K. R. Davidson.
1967 The Development of Health Services in a Rural Hospital Region. Administrative Report, Public Health Research Project No. 60-7-66.

Cooley, Charles H.
1922 Human Nature and the Social Order. New York: Schocken Books.

Cumming, Elaine and John Comming
1957 Closed Ranks: An Experiment in Mental Health Education. Cambridge, Mass.: Harvard University Press.

Davis, F.
1961 "Deviance disavowal: the management of strained interaction by the visibly handicapped." Social Problems 9 (summer): 120-32.

Dawson, W. R.
1911 "Relation between geographic distribution of insanity and that of certain social and other conditions in Ireland." Journal of Mental Science, 57:571-580.

Dayton, N. A.
1940 New Facts on Mental Disorders. Springfield Ill.: C. C. Thomas.

DeWitt, Robert T.
1969 Public Policy and Community Protest: The Fogo Case. St. John's: Institute of Social and Economic Research, Memorial University of Newfoundland.

Dohrenwend, B. P., Bernard, Y. W., and L. C. Kolb.
1962 "The orientation of leaders in an urban area towards problems of mental illness" American Journal of Psychiatry 118 (No.8): 683-691.

Durkheim, Emile
1897 Le Suicide. Paris: Felix Alcan. (Published in English as Suicide New York: Free Press, 1951).

Eaton, Joseph and Robert J. Weil
1955 Culture and Mental Disorders: A Comparative Study of the Hutterites and Other Populations. Glencoe, Ill.: The Free Press.

Enright, J. B., and E. R. Jaeckle
1963 "Psychiatric symptoms and diagnosis in two subcultures." International Journal of Social Psychiatry 9:12-17.

Erikson, K. T.
1962 "Notes on the sociology of deviance." Social Problems 9 (spring): 307-315.

Fandet, F. J. and R. I. Watson
1936 "Relations between insanity and marital condition." Journal of Abnormal and Social Psychology 30:366-71.

Faris, James
1966 Cat Harbour: A Newfoundland Fishing Settlement. St. John's: Insitute of Social and Economic Research, Memorial University of Newfoundland.
1969 "Mumming in an outport fishing settlement: a description and suggestions on the cognitive complex." In Herbert Halpert and

George M. Story (eds.), Christmas Mumming in Newfoundland. Toronto: University of Toronto Press.

Faris, Robert E. and H. Warren Dunham
1939 Mental Disorders in Urban Areas. Chicago: University of Chicago Press.

Firestone, Melvin M.
1967 Brothers and Rivals: Patrilocality in Savage Cove. St. John's: Institute of Social and Economic Research, Memorial University of Newfoundland.
1969 "Mummers and strangers in northern Newfoundland." In Herbert Halpert and George M. Story (eds.), Christmas Mumming in Newfoundland. Toronto: University of Toronto Press.

Freidson, Eliot
1961 Patient's Views of Medical Practice. New York: Russell Sage Foundation.

Girt, John
1971 Distance and General Medical Care in Rural Newfoundland. Unpublished report.

Glaser, Barney and Anslem Straus
1967 The Discovery of Grounded Theory. Chicago: Aldine Publishing Co.

Goffman, Erving
1961 Asylums. New York: Doubleday.
1963 Stigma. Englewood Cliffs, N. J.: Prentice-Hall.

Gove, W.
1970 "Societal reaction as an explanation of mental illness: an evaluation" American Sociological Review 35:873-884.

Hammer, M.
1963 "Influence of small social networks as factors in mental hospital admission" Human Organization 22:243-251.

Haber, L. and R. Smith
1971 "Disability and deviance: normative adaptations of role behavior." American Sociological Review 36 (February):87-97.

Hollingshead, August B. and Fredrick C. Redlich
1958 Social Class and Mental Illness. New York: John Wiley and Sons.

Hughes, E. C.
1945 "Dilemmas and contradictions of status." American Journal of Sociology 50 (March):353-359.

Iverson, Noel and D. Ralph Matthews
1968 Communities in Decline: An Examination of Household Resettlement in Newfoundland. St. John's: Institute of Social and Economic Research, Memorial University of Newfoundland.

Jaco, E. G.
1954 "The social isolation hypothesis and schizophrenia." American Sociological Review 19:567-77.
1959 "Social stress and mental illness in the community." In Sussman, M. B. (ed.), Community Structure and Analysis. New York: Crowell Co.

Kaplan, B., R. B. Reed and W. Richardson
1956 "A comparison of the incidence of hospitalized and non-hospitalized cases of psychosis in two communities." American Sociological Review 21:472-79.

Kesey, Ken
1962 One Flew Over The Cuckoo's Nest. New York: American Library Inc.'

Kitsuse, J. I.
1962 "Societal reaction to deviant behavior: problems of theory and method." Social Problems 9 (winter):247-256.

Labovitz, S.
1970 "The non-utility of significance test: the significance of tests of significance reconsidered." Pacific Sociological Review 13 (summer):141-148.
1971 "The zone of rejection" Pacific Sociological Review 14 (Fall): 373-381.

La Fave, H., Rootman, I., Sydiahia, D. and R. Duckworth
1967 "The ethnic community and the definition of mental illness." The Psychiatric Quarterly 41:211-227.

Leighton, Alexander H. et al
1959 My Name is Legion, Vol. I of the Stirling County Study of Psychiatric Disorder and Sociocultural Environment. New York: Basic Books.

Lemert, Edwin M.
1951 Social Pathology. New York: McGraw-Hill.
1962 "Paranoia and the dynamics of exclusion." Sociometry 25:2-20.

Lemkau, P., and G. Crocetti
1962 "An urban population's opinion and knowledge about mental illness." American Journal of Psychiatry 118 (No. 8):692-700.

Linsky, A.
1970 "Who shall be excluded: the influence of personal attributes in community reaction to the mentally ill." Social Psychiatry

5 (July):166-171.

Lofland, John
1969 Deviance and Identity. Englewood CLiffs, New Jersey: Prentice-Hall.

Malzberg, B.
1930 "Mental disease and the melting pot." Journal of Nervous and Mental Diseases. 72:379-85.

Mechanic, David
1962 "Some factors in identifying and defining mental illness." Mental Hygiene 46:66-74.

Mellor, C. S.
1972 A Preliminary Report on the Geographical Distribution of the Places of Origin of First Admissions, 1901-1970, to the Hospital for Mental and Nervous Diseases, St. John's, Newfoundland. Unpublished report.

Merton, Robert K.
1957 Social Theory and Social Structure. Glencoe Ill.: Free Press.

Myers, Jerome K. and Bertram Roberts
1959 Family and Class Dynamics. New York: Wiley and Sons.

Morrison, Denton E. and Ramon Henkel (eds.)
1970 The Significance Test Controversy. Chicago: Aldine Press.

Nunnally, Jum C. Jr.
1961 Popular Conceptions of Mental Health. New York: Holt, Rinehart and Winston.

Odoroff, M. and L. Abbe
1957 "Use of general hospitals: demographic and ecologic factors." Public Health Reports 72:397-403.

Parsons, Talcott
1951 The Social System. New York: The Free Press.

Phillips, D. L.
1963 "Rejection: a possible consequence of seeking help for mental disorders." American Sociological Review 28"963-972.

Ramsey, G., and M. Seipp
1948 "Attitudes and opinions concerning mental illness," Psychiatric Quarterly 22 (No. 3):428-444.

Reiss, A. J.
1961 "The social integration of queers and peers." Social Problems 9:102-119.

Rushing, W. R.
1971 "Individual resources, societal reaction, and hospital commitment." American Journal of Sociology 77:511-524.

Sampson, H., Messinger, S. L. and R. D. Towne
1962 "Family processes and becoming a mental patient." American Journal of Sociology 68:88-96.

Scheff, Thomas J.
1964 "The societal reaction to deviance: ascriptive elements in the psychiatric screening of mental patients in a midwestern state." Social Problems 11:401-413.
1966 Being Mentally Ill. Chicago: Aldine Press.

Star, Shirley A.
1952 What the Public Thinks about Mental Health and Mental Illness. Paper presented to The National Association for Mental Health, Nov. 19, 1952.
1955 The Public's Ideas about Mental Illness. Paper presented to the National Association for Mental Health, Nov. 5, 1955.

Stebbins, Robert A.
1971 Commitment to Deviance. Westport, Conn.: Greenwood Press.

Strauss, Anslem L. (ed.)
1956 George Herbert Mead on Social Psychology. Chicago: University of Chicago Press.

Sutherland, Edwin
1949 White Collar Crime New York: Holt, Rinehart & Winston.

Sydiahia, D., LaFave, H. G. and I. Rootman
1969 "Ethnic groups within communities: a comparative study of the expression and definition of mental illness." Psychiatric Quarterly 43 (winter):131-146.

Szaz, Thomas
1961 The Myth of Mental Illness. New York: Hoeber-Harper.

Wadel, Cato
1969 Marginal adaptations and modernization in Newfoundland. St. John's: Institute of Social and Economic Research, Memorial University of Newfoundland.

Wallace, Anthony F. C.
1961 Culture and Personality. New York: Random House.

Whitmer, C., and G. Conover
1959 "A study of critical incidents in the hospitalization of the mentally ill." Journal of the National Association of Social Work 4:89-94.

Zigler, E., and L. Phillips
1962 "Psychiatric diagnosis: a critique." Journal of Abnormal and Social Psychology 25 (summer):231:242.

Government Documents and Other Sources

1969 (a) Admissions and Separations from Psychiatric Institutions. Dominion Bureau of Statistics, publication 83-204.

1969 (b) Intercensual Estimates of Population. Dominion Bureau of Statistics, publication 93-107.

1969 Diagnostic and Statistical Manual of Mental Disorders, (second addition). Washington D. C., American Psychiatric Association.

1971 An Act Respecting Mental Health. Government of Newfoundland and Labrador (No. 80).