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Mental health care in the community: An analysis of contemporary public attitudes towards, and public representations of, mental illness

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Abstract
Public tolerance of, and non-discrimination towards, people with mental health problems are key factors on which success in achieving the goal of community-based mental health care depends. This paper revisits Thomas Scheff's (1966) sociological theory of mental illness, and tests elements of this thorough critical review of recent UK literature relating to public attitudes towards, and media representations, of mental illness. Negative representations predominate in the media, while a significant minority of the UK public appear to possess negative attitudes towards people with mental health problems and their care and social participation in the community. These findings support aspects of Scheff's theory. Implications for policy and practice are discussed, including the need to challenge stigmatising and discriminatory attitudes and behaviours.

Introduction

Success in realising the broad goal of providing community-focused care for people with mental health problems is dependent upon the achievement of a number of key conditions (Repper & Brooker, 1996). These include: the establishment of comprehensive community alternatives to in-patient care, particularly for people with severe and enduring mental health problems (Department of Health, 1996; Welsh Office, 1996); the affording to people experiencing mental health problems all the rights of full citizenship as are afforded to other individuals throughout the UK (Perkins & Repper, 1996); and tolerance and non-discrimination on the part of local communities (Bhugra, 1989).

This paper is concerned with the latter two of the above conditions. The aims therefore are: to explore attitudes towards mental illness; to explore attitudes towards people experiencing mental health problems and their care in the community; and to explore public representations of mental illness.

To provide a coherent theoretical framework within which to review recent empirical studies which have investigated these issues, Thomas Scheff's sociological theory of mental illness is used (Scheff, 1966). The utility

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of Scheff's model in this context is its concern with the social processes propelling individuals towards the acquisition of mental illness diagnoses and their subsequent 'careers' as patients. Much of Scheff's work therefore deals with social perceptions of deviant behaviour, public attitudes towards, and social reactions, to mental illness (as one form of deviancy) and the stigmatisation of individuals labelled mentally ill.

Scheff's expectation some 33 years ago was that his theory, in whole or in part, would be tested in the light of empirical research (Scheff, 1966, p. 25). In a modest way, this review and discussion attempts this, by locating recent research evidence and using this to test particular elements of Scheff's work.

Examination of community attitudes towards, and representations of, people with mental health problems presents itself as a particularly appropriate task for a number of reasons. There have, for example, been recent suggestions that central government has considered root-and-branch review of community mental health care, ostensibly to maintain the safety of the public (Thomson & Sylvester, 1998). This has reportedly been in response to high-profile, but isolated, incidents in which vulnerable people with mental health problems have taken the lives of strangers or family members (see, for example, Ritchie *et al.*, 1994). Indeed, policy initiatives in recent years, while supportive of community-based care, have reflected this concern with public safety, emphasising as they have the formal supervision of patients in the community (Department of Health, 1994; Mental Health (Patients in the Community Act), 1995). Against a background of 'moral panic' (Holloway, 1996), specific policy measures may have fuelled already fearful and intolerant public attitudes towards people with mental health problems (Wells, 1998).

A general introduction to Scheff's project will first be offered. Following this, a partial evaluation of his social systems theory will be attempted, achieved through the use of selected contemporary studies to test three of Scheff's nine specific propositions.

In order to locate as comprehensive and up-to-date a range of published material as possible, a systematic search strategy was used. Following the method described by Repper & Brooker (1996), the acquisition of literature commenced with a systematic interrogation of three widely-used electronic databases: *Social Science Citation Index*; *Cumulative Index of Nursing and Allied Health Literature* (*CINAHL*); and *Medline*. Keywords used were those employed by Repper & Brooker (1996), namely *mental illness* in combination with: *public attitudes*; *stigma*; and *community facilities*. This strategy successfully identified a wide range of original research, review and opinion papers, dating from the 1960s to the present. Most of these appeared to have been produced by North American social scientists and psychiatrists. Given this, the pragmatic decision was made to select for discussion only papers generated by United Kingdom authors, and for the most part only those published from 1990. In addition, publications referred to by database-identified authors were also occasionally consulted.

Scheff's sociological theory of mental illness

In *Being Mentally Ill: A sociological theory*, Thomas Scheff (1966) was concerned to develop a theoretical model of mental illness grounded in the analysis of social systems.

Before presenting his model, Scheff commenced with an overview of prevailing psychological and psychiatric formulations of mental illness. Scheff was at pains to ac-

knowledge the success of approaches derived from these broad perspectives, particularly in underpinning research into, and treatment of, mental illness. Nonetheless, he continued his analysis by observing that:

> 'Genetic, biochemical, and psychological investigations (into mental illness) seek different causal agents, but utilise similar models: dynamic systems that are located within the individual. In these investigations, social processes tend to be relegated to a subsidiary role, because the model focuses attention on individual differences rather than on the social system in which the individual is involved.' (Scheff, 1966, p. 9)

For Scheff, this narrow focus on the individual made traditional approaches to understanding mental health and illness incomplete. However, in introducing his social systems approach as an alternative, Scheff also acknowledged the limitations of his own perspective. For, just as conventional models of mental illness overemphasised the individual, so did his model overemphasise the social. 'The social systems model', he stated, '*holds constant* individual differences, in order to articulate the relationship between society and mental disorder' (Scheff, 1966, p. 25). Scheff's expressed hope was that, by presenting a model of mental illness which was the deliberate antithesis of individualistic approaches, by dialectical progression a synthesis of models would arise: 'a model which has the advantages of both the individual and the social system models, but the disadvantages of neither' (Scheff, 1966, p. 27).

Reflecting on these initial observations over thirty years after their appearance, it is striking how relevant Scheff's ideas remain today. Advances from the fields of psychology and psychiatry have continued to benefit individuals experiencing mental health problems, but have failed to provide convincing all-encompassing explanations of the nature of mental health and illness. Exclusively individualistic explanations, therefore, still appear incomplete. Similarly, the role of social processes in understanding mental health and ill-health is now widely accepted (Pilgrim & Rogers, 1993), but a social model alone also seems inadequate without some conception of the individual and of individual difference. The general recognition of these inadequacies, therefore, may go some way in explaining the current interest in models which acknowledge the place of both internal and external factors in the causation and triggering of mental ill-health (see, for example, Zubin & Spring, 1977).

Scheff's detailed theory commenced with a consideration of rule-breaking and deviance. The former, he stated, 'refers to behaviour which is in clear violation of the agreed-upon rules of the group' (Scheff, 1966, p. 31). These rules, or social norms, Scheff held were numerous, and governed a wide range of social events. Frequently these social norms, such as those governing social interaction, achieved high levels of consensus among members of social groups, but were rarely explicit. Deviance, Scheff continued, was a function of societal reaction against those who breached such norms. It was not, therefore, a function of the individual act of rule-breaking itself, but rather the nature of the group's response. Consequently, 'the deviant is one to whom that label has successfully been applied' (Becker, cited by Scheff, 1966, p. 32).

Often the breaching of social norms attracted particular descriptive deviant labels which related to the characteristics of the rule involved. Examples included alcoholism, or crime. Mental illness, however, Scheff described as an example of 'residual rule-breaking', as the norms broken by the person so

labelled were likely to be diverse and non-specific.

Scheff's specific propositions and recent empirical evidence

Having established the foundations of a social systems model of mental illness, Scheff elaborated nine specific propositions, each of which he saw as potentially verifiable by empirical research. For the sake of completeness, each will be presented and outlined below. Only the three propositions most pertinent to the aims of the present study, however, will be tested through review of the recent UK literature.

Propositions one to three

Scheff's first three assertions were concerned with mental illness as deviance, and in particular the origins, prevalence and most common societal reaction to rule violation. As such, these propositions fall largely outside the scope of this paper, as the aim here is the exploration of attitudes and behaviour towards those who have already been identified as mentally ill. Briefly, therefore, these three statements are:

1. Residual rule-breaking arises from fundamentally diverse sources (Scheff, 1966, pp. 40–47).

Both internal and external factors are possible origins of rule-breaking. Mental illness may therefore have as its source organic disturbance, stress, and much else besides.

2. Relative to the rate of treated mental illness, the rate of unrecorded residual rule-breaking is extremely high (Scheff, 1966, pp. 47–50).

Most breaches of social norms are not noticed, are ignored, or are otherwise denied. Only under particular conditions are residual role violations labelled as mental illness.

3. Most residual rule-breaking is 'denied' and is of transitory significance (Scheff, 1966, pp. 51–54).

Arising from proposition two, this holds that most rule-breaking, having not been labelled as mental illness, is relatively short-lived. Only under certain conditions is rule-breaking identified as mental ill-health.

Propositions four and five

In introducing his next two propositions, Scheff was concerned to consider mental illness as a social institution. Both therefore have direct relevance to the exploration of public attitudes towards mental illness; proposition five particularly will be used to frame discussion of recent relevant empirical research.

Through the application of propositions four and five, Scheff was concerned to demonstrate how, for some individuals in some sets of circumstances, the social reaction to residual rule violation was not denial but labelling. Scheff argued that, at moments of crisis when an individual's deviance became a public issue, the group would fall back upon their stereotyped model of mental illness. In response, the person labelled as mentally ill tended to conform also to the group's stereotyped image. In this way, Scheff went on, residual rule breaking became 'crystallised' and stable. The very act of labelling an individual as mentally ill, therefore, became a critical 'contingency' in the initiation of that person's mental illness career.

The propositions are:

4. Stereotyped imagery of mental disorder is learned in early childhood (Scheff, 1966, pp. 64–67).

The socialisation of children includes exposure to prevailing social images of deviancy. Children therefore very quickly learn adult stereotypes of mental illness, and incorporate stereotypical language into their everyday talk.

Scheff acknowledged that there was, in the mid-1960s, limited evidence of childhood acquisition of stereotypical (and mostly negative) images of mental illness to support this proposition. Recent empirical studies examining public images of mental illness also tend to exclude children from their samples (see below for discussion of these), making the acceptance or rejection of this proposition difficult. Philo *et al.* (1994), in their analysis of one month of media reporting of mental illness, included scrutiny of material produced for children. This study is referred to in detail below. Also, while not offering empirical evidence to support this proposition, Byrne (1997) directly cited Scheff's fourth proposition to alert his largely medical audience to the probable early evolution of negative attitudes towards mental illness.

5. The stereotypes of insanity are continually reaffirmed, inadvertently, in ordinary social interaction (Scheff, 1966, pp. 67–80).

Adults are exposed to alternative models of mental illness, including medical and psychological models. However, the stereotypes learned in childhood are continually reinforced through both the media and everyday social interaction.

There is considerable recent evidence from the UK to support this key proposition. Philo *et al.* (1994) demonstrated that, of all media reports studied over a period of one month which dealt with mental health/illness, two-thirds linked mental illness with violence.

The implications of selective negative reporting of this nature have been extensively discussed elsewhere. McKeown & Clancy (1995), for example, argued that although the relationship of the media to public attitude-formation was complex and unclear, negative images were likely to reduce the quality of life of people with mental health needs. Similarly, Lehane & Rees (1996) argued that negative media images were likely to increase the stress already suffered by people with mental health problems. Glasson (1996), while considering media reports of serious public incidents involving people with mental health needs, argued that 'sensationalisation' ran the risk of significantly bolstering an already-negative public attitude towards mental illness. Philo (1997) argued that negative media images made people with mental health needs less likely to seek help, fearing that families and friends might make erroneous judgements concerning the risk to them of violence by the sufferer. Reporting an investigation into one community's attitudes towards the relocation of people with mental health problems from hospital to community facilities, Reda (1996) found that respondents' attitudes were overwhelmingly negative. This was felt to be at least partly a reflection of negative media reporting. Finally, writing at the end of the last decade, Appleby & Wessely (1988) reported a temporary, but statistically significant, increase in public support for the statement that 'People who commit horrific crimes, such as murder of children or old people, are likely to be mentally ill' in the wake of the Hungerford massacre of 1987. In their discussion of this finding, supported by direct citation of newspaper headlines reporting the tragedy, they suggested that speculative news accounts of the perpetrator as a 'madman' or 'maniac' may well have played a part in modifying public attitudes in this way.

Researchers have recently attempted to evaluate the impact of explicit public education programmes regarding mental health and illness, prior to the opening of new community care facilities. Wolff *et al.* (1996a) found that their public education campaign did not significantly improve their experimental group's knowledge of mental illness. It did, however, change their attitudes towards mental illness for the better, and lead to

closer integration between residents of the new facility and members of the local community.

Propositions six to eight

In presenting his following three hypotheses, Scheff was interested in demonstrating how the initial labelling of the deviant individual as mentally ill came to be accepted by the individual him/herself.

6. Labelled deviants may be rewarded for playing the stereotyped deviant role (Scheff, 1966, pp. 84–86).

The status of the labelled individual implies a particular social role, including acceptance of the putative mental illness as a valid descriptor of deviant behaviour. Psychiatrists, fellow patients and others all encourage the patient to accept the label and to interpret personal experiences in the light of the mental illness diagnosis.

Related to this, Scheff suggested that:

7. Labelled deviants are punished when they attempt the return to conventional roles (Scheff, 1966, p. 87).

Once the label has been attached to the individual, discrimination in a range of spheres prevents the person from returning to his or her former social status. This stigmatisation extends to the spheres of employment, interpersonal relationships and to the wider social world.

A considerable number of studies completed in the present decade lend support to this last hypothesis, each revealing stigmatising and discriminating attitudes on the part of a substantial minority of members of the public.

One frequently used methodological approach in investigations of this sort has been the use of vignettes (but see Cowan, 1994, for a critique of this approach to attitudinal research). Study participants are provided with brief descriptions thought to be typical of particular mental illnesses, either with or without an attached diagnostic label. Participants are then questioned in an attempt to establish attitudes towards, knowledge of, or probable behaviour towards the person or problems described.

Vignettes were presented to some 2000 members of the public living in two areas in the Midlands in the study reported by Hall *et al.* (1993). Interestingly, only around one-quarter of participants suggested 'mental illness' as a possible cause of the problems outlined in the vignette designed to be descriptive of schizophrenia. This arguably provides some support for Scheff's assertion that most deviant behaviour is not labelled as mental illness (proposition two above). Elsewhere in this study, there was evidence of public tolerance towards mentally ill people, though differences were found among participants according to age, gender, educational attainment and class. Overall, while nearly all respondents (93%) mentioned that they would speak to people presented in the vignettes, only 59% mentioned that they would work with them, only 51% mentioned that they would live next door to them, and less than half mentioned allowing their children to speak with them.

Reported in a separate paper by Brockington *et al.* (1993) were the findings of face-to-face interviews held with the same respondents as included in the above vignette research. Here, further evidence of tolerance towards people experiencing mental illness was found, though once more significant differences were reported within the study group. Factors associated with greater tolerance included: acquaintance with mental illness (either through personal experience, or closeness to others who had experienced or were experiencing mental ill-health); age between 25–44 (older and younger respondents appeared less tolerant); higher managerial occupational status; and high level of completed education.

Levey & Howells (1995) also used vignettes as one of their methods of investigation, this time to explore perceptions of schizophrenia held by members of the public, and psychology and nursing students. Particularly notable was their finding that people with schizophrenia tended to be thought of as essentially 'different', in terms of their perceived unpredictability and dangerousness. Furthermore, it was this difference which was found to underpin the widespread fear of schizophrenia held by many of the study's participants.

Case vignettes were employed by Ingamells *et al.* (1996) to investigate attitudes among 208 residents of two areas, one situated near a psychiatric hospital, the other near a community facility. Respondents were found to be more rejecting where they believed that the person described in the vignette was mentally ill. As in the study reported by Brockington *et al.* (1993), people with personal experience of mental ill-health were more likely to display accepting attitudes. Age was again related to attitude, with, in this study, younger people found to display greater tolerance.

Finally, Wolff *et al.* (1996b; 1996c) conducted interviews and administered questionnaires to members of the public in two areas of London, both of which were due to become home to people discharged from the local psychiatric hospital. Again, socio-demographic variables were associated with particular attitudes. Examples included the findings that older people tended to express more controlling attitudes, while people in higher social classes tended to be less controlling. Social control, moreover, was also found to be associated with lack of knowledge of mental health and illness on the part of respondents.

Reviewing these recent investigations into public attitudes towards mental health and illness and towards community mental health care, it would seem reasonable to argue that, at the very least, a substantial minority of the UK public is not overwhelmingly keen to welcome mentally ill people into full community and occupational life. Identifying people with mental health problems as essentially 'different', expressing reluctance to live or work alongside mentally ill people, and expressing controlling attitudes all lend considerable support to Scheff's hypothesis that social groups may prevent people labelled as mentally ill from returning to their former social roles. Taken to its most extreme, this stigmatisation may even lead to the harassment and victimisation of people with mental health problems living in the community, a particular problem discussed by Kelly & McKenna (1997).

8. 'In the crisis when a residual rule-breaker is publicly labelled, the deviant is highly suggestible, and may accept the proffered role of the insane as the only alternative' (Scheff, 1966, pp. 89–91).

At the point of public recognition of the crisis, the individual in a state of confusion and anxiety is likely to accept the explanations of his or her deviance offered by the social group. As a member of this social group, the labelled individual may begin to interpret his or her experiences in the light of the prevailing social stereotype of mental illness, and even modify his or her behaviour to fit the image.

Proposition nine

Finally, Scheff observed that his preceding eight propositions led to one final assertion. That is:

9. 'Among residual rule-breakers, labelling is the single most important cause of careers of residual deviance' (Scheff, 1966, pp. 92–93).

It is the very fact of labelling which is the most important contingency in the development of the individual's career as a mental patient.

This may be Scheff's most controversial statement, for here he claims that it is the social act of labelling, rather than any individual factor or any combination of individual and social factors together, which is the most important variable in propelling the individual towards a lifetime of mental illness.

Conclusion: Implications for policy and practice

Labelling theory was once a favoured perspective within the sociology of mental health and illness. Perceived weaknesses contributing to its loss of status from the 1970s onwards, summarised by Pilgrim & Rogers (1993, pp. 18–19), include: that the theory underestimated the underlying causes of primary deviation; that public stereotypes of mental illness and the actual behaviours exhibited by people with mental illnesses were not always consistent; and finally, the precise features of the contingencies which determine deviancy either being ignored or being labelled were not adequately explained in the model. The accumulated evidence presented here, however, suggests that, in significant respects, key elements of Scheff's labelling theory do stand up to empirically-based scrutiny. In particular, public representations of mental illness do convey overwhelmingly negative stereotypes. Also, among at least a minority of members of the public, negative and stigmatising attitudes are held towards people with mental health needs, their care in community settings, and their participation in social life.

Scheff (1966, p. 101) suggested ways in which verification of other elements of his theory could be attempted. These could usefully form the basis of further studies. To conclude this paper, however, some implications for mental health policy and practice arising from the analysis presented will be offered.

There appears to be a clear place for public education (Byrne, 1997; Hayward & Bright, 1997). Aims could include the enhancing of public knowledge of mental health and illness, in an explicit attempt to counter prevailing and misleading stereotypes. As research evidence has suggested that particular groups in society are more likely than others to display negative attitudes, and presumably therefore, behaviours, then education programmes could usefully target those thought to be most stigmatising and discriminating.

In a climate of 'moral panic', balanced reporting of mental health issues would be welcome (Philo *et al.*, 1994; Lehane & Rees, 1996). Similarly, careful consideration of future policy initiatives, directed less towards control and more towards integration and inclusion of people with mental health needs, would be helpful. As full participation in community life, including access to employment opportunities, appears to be limited by the restrictive attitudes and beliefs of a substantial minority of the UK public, there may in addition be an argument for a policy-led solution to discriminatory practice. Such an approach has recently been advocated by Brunton (1997).

Finally, labelling and stigmatisation of people with mental health problems represents a particular challenge to mental health workers of all disciplines. In this respect, it is welcoming to read of the possible recent reawakening of interest in stigma and its effects among professionals and others, as measured by rates of publication of related papers in journals (Hayward & Bright, 1997). Central tasks for all practitioners are therefore coun-

tering unhelpful stereotypes, promoting tolerance, knowledge and understanding, and working towards the full inclusion in social life of people with mental health needs.

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