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A study of a mental health panel

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Boston University
A STUDY OF A MENTAL HEALTH PANEL

A thesis
Submitted by
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</tbody>
</table>
This thesis was written while the author was engaged in field work at the Massachusetts Mental Health Center. Special thanks are in order to Miss Anne Ogilby, head of the House Social Service Department. She is not only the leader of the panel but its originator, and her great familiarity with its history, structure, and function, served as the foundation for the present piece of research. Thanks are also in order to Mrs. Rose Elbaum, author of a study prepared for the Simmons School of Social Work in 1956, *The Psychiatric Social Worker as Mental Health Educator*, whose bibliography provides an excellent coverage of the recent literature in the field.
I. INTRODUCTION

The Problem: An Evaluation of the Effectiveness of the Panel.

A panel of speakers from several hospital services including psychiatry, nursing and social service, who speak on the work of the psychiatric hospital, has just completed its tenth year of community education in and around Greater Boston, under the auspices of the Massachusetts Mental Health Center.

The purpose of this study is now to seek some index of its effectiveness, to consider how the findings may serve as a guide to practice for the panel itself and for other programs in the mental health education field, and to recommend areas for further study.
The Reasons for the Study: The Need for Sound Mental Health Education.

It is a well known fact that the number one public health problem of the United States today is mental illness.\(^1\) Indeed, with the passage of the National Mental Health Act in 1946, its amelioration became a matter for federal responsibility.\(^2\) The gravity of the need makes clear the importance of finding the resources with which it can be met. And prominent among these is mental health education.

"Mental health," Karl Menninger has defined as "the adjustment of human beings to the world and to each other with a maximum of effectiveness and happiness."\(^3\) And "mental health education," Nina Ridenour has defined as "what you do in order to enable people to understand more about how to achieve mental health."\(^4\)

These are broad concepts. Other students of the field have defined them in other ways. But it is against the background of this thinking that individual programs take their place and their importance, as it is hoped the program under study can illustrate. Broadly, it demonstrates the concern of informed experts for lay understanding. Specifically, it demonstrates one technique in common use for public education, the discussion panel. Anything that can be learned about the effectiveness of this technique should contribute to the wider picture.

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1. Mike Gorman, Every Other Bed, p. 22.

To measure the effectiveness of the program the author decided to examine and compare the opinions of both panel participants and audience members, on the theory that where the opinion of "experts" and "laymen" coincide a program can be deemed effective, and that where they differ the program can be deemed open to question.

Something of the more detailed reasoning behind this selection of method will be separately considered in APPENDIX A., OPINION COMPARISON AS A METHOD OF EVALUATION. For the immediate project the author would like to quote Miss Ridenour:

Mental health education, like other social sciences, frequently lacks measures of change from which the definitive criteria of effectiveness can be derived.

This is the problem of the field, and not the result of the naïveté of the workers in the field...

But while it is true that actual measures are scarce, still evidence of change is not by any means lacking.5

In pursuit of this evidence, the author has therefore called upon two techniques for the collection of data: personal observation, and questionnaires. Two questionnaires were in fact employed, the first to determine audience objectives in coming to hear the Panel, and the second, to be administered both before and after the presentation, to determine audience attitudes and the changes effected in these attitudes. (Both questionnaires are to be found at the end of this study, listed as APPENDIX B and APPENDIX C respectively.) Both were also to be administered to the panelists, not for their own opinion, but for their estimate of audience opinion.

The Subjects: Ten Panelists and Three Audiences

The experts tested were ten panel members, each active in the program either this year or last: two psychiatrists; two psychiatric social workers; two psychiatric nurses; one occupational therapist; one vocational therapist; and two former patients.

The laymen tested were three community groups sponsoring the Panel; the Wives of a Fraternal Order (on November 28, 1957); the members of an Inter-Church Council (on January 15, 1958); and a Church Women's Auxiliary (on January 29, 1958).

Taking the three groups collectively, 116 individuals attended the presentation. Of these, 52 completed the questionnaires, or a total of 45 per cent (See TABLE I, below). A larger sampling would have been preferred, but none was possible within the limits of the research time-table.

<table>
<thead>
<tr>
<th>Audience</th>
<th>Total Attendance</th>
<th>Total Respondents</th>
<th>Percentage Responding</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Wives&quot;</td>
<td>39</td>
<td>18</td>
<td>46</td>
</tr>
<tr>
<td>&quot;Council&quot;</td>
<td>44</td>
<td>23</td>
<td>53</td>
</tr>
<tr>
<td>&quot;Auxiliary&quot;</td>
<td>33</td>
<td>11</td>
<td>33</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>116</strong></td>
<td><strong>52</strong></td>
<td><strong>45</strong></td>
</tr>
</tbody>
</table>
Reliability and Validity

Neither reliability nor validity are claimed for so small a study. The first could be determined only by repeating the tests on the same subjects, or on very similar subject groups, and such a project was not a part of the research design. The second, validity, could be verified only by checking the data results against some independent criteria, and none are known to the author that would be relevant. The whole study is merely a first exploration of the topic. The results must stand just as some perhaps useful indications of a few of the facts.
II. DESCRIPTION OF THE PANEL

Agency Setting

The Massachusetts Mental Health Center under whose auspices the panel functions was established in 1912 as the Psychopathic Hospital of Boston, Mass., a diagnostic unit of the Massachusetts Department of Mental Health. Rechristened in 1956, it is now famous for its treatment, teaching and research programs, with a history of activity in community education dating back to the interest of its first director in what he called "industrial psychiatry," a two-pronged effort to recruit employers for job openings for released patients, and to enlist the supplementary services of other social agencies.

Historically the execution of this program was put under the department of social service, whose first chief as early as 1922 defined the functions of her service as:

The gathering of social histories; casework with families; casework, though to a lesser extent, with patients; inter-agency referrals and liaison; research; teaching; and, finally, the mental hygiene of industry.

With the arrival in 1928 of the department's fourth and present chief, yet another aspect of public contact was started, work with lay groups; and it was from this last that the panel eventually evolved, with the result that although its presentation is inter-disciplinary in character, its administration, by reason of origin, continues under social work.

6. Milton Greenblatt and others, From Custodial to Therapeutic Patient Care in Mental Hospitals, p. 39
7. Vernon L. Briggs, History of the Psychopathic Hospital, Boston, Mass., p. 175.
9. Cook, Esther, Interview
Historical Development

Specifically, the panel grew out of a treatment group for patients' relatives opened in 1947-48 by Miss Anne Ogilby, originator of the panel and still its leader, who recalls:

I was the only house caseworker at that time, and I was so swamped that to meet as much of the need as possible I started a weekly group therapy session for patients' relatives, 20 to 40 of them. The meetings were completely open. And as they went along we all became impressed by the problems that both the families and the patients face when the time comes to go back out into the community.

We felt that much of the trouble was simply due to ignorance on the part of the general public, and that, until we tackled the community, our patients would continue to have a rotten time of it. Several of the group members became quite crusading minded and felt that more people in their own communities should know something about mental health. Finally one mother arranged for me to go out and talk to a club she was a member of, and that was the beginning of it all.¹⁰

The program remained a one-speaker presentation, however, until the autumn of 1948, when on the day she was scheduled to address an audience of 400 the leader succumbed to virus. Unwilling to fail the group and unsure of her ability to remain on the stage, she persuaded a nurse and an occupational therapist at the last minute to come and help out as co-speakers. Things went so well that next time a psychiatrist was added, and thereafter the inter-staff approach became fixed, crystallizing into its present form in 1952-53 when first a patient's mother was added to the panel, then finally, instead, a former patient himself.

Today the panel has acquired several distinguishing characteristics. For one, it can point to an unusual continuity and longevity. For another, it never solicits engagements or stipulates fees, even for travel

¹⁰. Anne Ogilby, Interview
costs. All donations are turned over intact to the hospital's patient
government fund. Engagements are scheduled only as they are requested by
voluntary citizens' groups. Over the years the requests have steadily in-
creased. The speakers meet them, furthermore, not as a part of their regu-
lar staff duties, but by the donation of their own free time. And the
presentations are unified in the form of a presentation of a case history,
the actual experiences of the patient who speaks with the panel. Some of
the reasons behind these developments will be given in the following sec-
tions.
Five speakers make up the panel now, a psychiatrist, a psychiatric nurse, a psychiatric social worker, an occupational therapist, and a patient.

Over the years this composition has varied both as to number and departmental representation: the hospital chaplain has served, a psychologist, a vocational rehabilitation expert, and, upon occasion, a volunteer; also, as noted, the relatives of patients.

To ease the engagement schedule, several members of each discipline rotate. And at the present time there are five patients who have volunteered, all of them women.

Ten of the panelists, each active within the past two years, were, as noted in the preceding chapter, interviewed for this study. A full analysis of their motivation for participation is beyond the range of the present project. They had a good deal to say, however, on why they considered the work personally worth while, and something of this should be mentioned for the light it casts on their presentation and the attitude they bring to the audience.

** "Part of getting well," one patient said, "is being able to admit you've been sick. And if the audience sees a patient up there who's just like himself, they may think, well, this can't be so terrible after all."

** "I was unhappy with the interpretation of psychiatric nursing," a nurse reported. "I joined primarily to help get across a picture of something more therapeutic and less custodial."

** "I'm interested in education in all its aspects," one doctor said, "Change? No. This panel can't do that. But it can reinforce a lot of other influences already at work in the community. It can help an audience look a little more closely at itself. They may make a little more effort. It makes for tolerance and understanding."
In general the speakers see the panel as work-related. They hope it can help patients by preparing the community for their return; they hope it can help the community with its own questions about mental illness; enlist support for mental health as an overall program; advance the interpretation of their various disciplines; and sharpen their individual professional skills.

Despite the fact that all donate their own free time to work on the panel, the questions they also raise about it all have to do with regret that they cannot give it even more time. They would like to know more about audience structure and psycho-dynamics. They would like advance surveys and follow-up assessments. They would like to clarify more material than they can attempt at present. And they would like to know that the points the program tries to make are made successfully.
Audiences

A community is a structure whose capacity for achievement is greater than the sum of that of the individuals who compose it . . . A crowd is the raw material of a community, unorganized, not pointed up in its goals.11

The panel, except for two radio and one TV program, has spoken only for organized community groups, by inference pre-structured audiences which the leader believes to be cohesive, highly motivated, and, in one way or another, effective in community action.

Usually the group falls into one of five categories: professional, such as the New England Hospital Association, the New England Nursing Association, and the Newton-Wellesley Hospital; educational, such as parent-teachers associations, Brandeis University, the Simmons School of Social Work; religious, such as councils of churches, young couples clubs, and women's auxiliaries; service, such as Rotary Clubs and branch chapters of the Florence Critendon League and the League of Women Voters; business, such as Junior Chambers of Commerce. (To date no invitations have yet been received from labor groups.)

For many groups the panel holds number one place on the year's agenda, they give the program good advance publicity, repeat requests are not uncommon, and invitations from "new" groups as a rule come by word-of-mouth recommendations from "old" groups.

No record of engagements has been kept, but it is the panel leader's impression that the majority of sponsors have been women's groups, with "co-ed" following in second place by courtesy of many church couples clubs.

and P.T.A.s. Groups exclusively of men such as Kiwanis and the Chamber of Commerce have been new within the past three years.

Engagement preliminaries are minimal. Requests come both by letter and phone. As the panel accepts only two invitations a month, -- December and the summer months excluded -- the leader selects those she thinks most worth while in terms of community impact. The others are offered a single speaker, or an abbreviated two or three member panel. No requests are turned down completely. Little change in procedure or presentation is planned, from group to group. Invitations are consistently declined to attend business meetings and/or club dinners that usually precede the program, as the speakers have found from experience that the formalities are too tiring.

As to the social action resulting later from the programs, no record has been kept. The leader can, however, name between 20 and 30 volunteers who have come forward to join the hospital's auxiliary. One ultimately became the institution's assistant librarian; another, who was the wife of a bishop and an enthusiastic amateur gardener, brought back the occupational therapy greenhouse from a period of weedy decline; through another a suburban parish made a special project for a number of years, giving bi-annual teas for the patients.

Private beaches for summer picnics have been offered, magazines and books contributed to the patients' library, much wanted records given to the music room, and Christmas gifts supplied for patients without families. Several jobs have been forthcoming from employers in the audience, including one held by a present patient panelist. And the leader furthermore reports an average of three or four voluntary
admissions each year resulting from the programs. She assumes other contacts have also been made by audience members with private psychiatrists and community clinics, although as to the follow-up on this the panel would, of course, have no way of knowing.
Presentation

Over the years the panel has developed a fairly standardized format, centered, as has been said, in a single case history. The leader consistently sees that the speakers' table and audience chairs are in close proximity to set an atmosphere of informality. The tone of voice of all the speakers is conversational, the language is kept consciously simple and direct. "We follow the 'Semradian' principle," the leader says, "of sticking to terms that anybody can understand."¹² (This in accordance with the practice of Elvan V. Semrad, the Center's Clinical Director.) The presentation is kept down to forty minutes, with another twenty allowed for a question period, as it is felt that it is then that much of the important interaction takes place. In general the two objectives are audience identification and audience participation.

Close to the beginning and close to the end two "shock techniques" are employed that the leader calls "attention getters."

The first comes when the leader, having introduced the members of the panel and the program topic, mental health in a state mental hospital, then says that this is a far from abstract problem. One in ten of all of us in the United States will at some point in life enter such a hospital for its care. And, to drive home the point, she computes the number of persons in the audience and the number who will consequently be affected, pointing out that if only through our friends the problem concerns us all.

This opening has been the subject of some debate within the hospital, even being discussed at Noon Staff. One school of thought has it that the

¹² Anne Ogilby, Interview
impact is traumatizing, raising audience anxiety to such a pitch that concentration on the program that follows is interfered with. The other school holds that it gets the audience down to business, creates a real identification with the patient whose case history is next heard, and, by enlisting sympathy, enables a greater social response. The leader is familiar with both lines of thinking, and admits the introduction raises anxiety, but feels that this can be adequately handled both by the reassuring nature of the story that follows and by the question period when individual questions come to light.

The body of the program opens with the leader, this time speaking as the social worker, describing the intake process and giving something of the particular circumstances that brought "Marge," or "Pat," or "Judy," as the case may be, to the hospital, together with the new patient's feelings about having to enter a mental institution. The nurse then describes escorting her from the admission office upstairs to the ward, in the process giving a picture of the hospital and the climate one finds there. Then each staff panelist in turn speaks about his own share in the patient's treatment and cure, in the process explaining the psychiatric principles involved. The composite result is not only a "human interest" story but also a description of a state mental hospital and an exposition of its psychiatric practice.

Throughout this exposition the patient, however, has not spoken. She may have been sitting at the table, introduced merely as a "volunteer," or she may have been sitting among the audience, unidentified. Now comes the second "attention getter." What, the speaker asks, has become of (first name) since she left the hospital? When she finally recovered, how did
she make out? "I know of no one who can tell us about that as well as she can! It is with great pride that I now introduce (first name) herself."

And with this the patient comes forward and closes the formal program with a short account of her own experiences getting back into the community, and a plea to the audience to help create a greater understanding for yet other patients who must still make the same difficult step.

A ripple of reaction invariably runs through the audience when the patient moves to the center. Neighbors lean their heads together. Some fold their arms and look frankly incredulous. Sometimes tears are to be seen. One audience the author observed burst into spontaneous applause. The meeting ends on a note of some intensity.

On this procedure also there are two schools of thought. Some hospital staff feel that it introduces an element of confrontation that makes an audience feel uncomfortable, even guilty. They have been "caught" following an intimate story when their point of view might have been somewhat different if they had known from the start that the patient was present. Others feel that "seeing is believing," and that the whole claim that cure is possible gains impact when the results can be thus demonstrated.

As to the question period, though, there is no difference of opinion. It is uniformly regarded as of great importance for catching and correcting misunderstandings, picking up anxieties, answering individual questions, and channeling interest in social action. Even after the question period, two or three panel members also make a point of staying on for more personal chats, and, when indicated, to recommend appropriate agencies for special help. Referrals are made not on the basis of the Center's resources alone, but for all mental health facilities within the Commonwealth.
Informally, the panelists feel that audience response usually fall into four groups: 1) The tributes! "I want to say how wonderful --". The majority of these are directed to the patient. Indeed, she seldom gets any of the other categories. 2) The psychiatric worries! "I have a friend who --". Sometimes the friend is thought to be the questionner in disguise. 3) The complaints! "Why is it that --?" Usually the asker has a friend or relation who had a negative experience with psychiatry. More occasionally he is personally hostile to the field. By policy the panel invites free expression of feeling, tries to provide assistance where possible, but never becomes argumentative or defensive. 4) "Other." Everything from questions on the relationship between psychiatry and religion to requests for guidance on social action.
III. OBJECTIVES OF THE PANEL

In a study of the panel, the first point that should be considered is the extent to which the objectives of the panelists in presenting the program and the objectives of the audience in attending may coincide or differ. What, in other words, motivates an audience to come? What points of information do they seek? And to what end? Does the program speak to their expectations? And do the panelists estimate these correctly? In general, what is the success of the two groups in agreeing as to the ground that should be covered between them?
Objectives Set for the Program by its Leader

Among the panelists there has been no collective discussion as to what the specific objectives of the program should be. To provide a starting point for research, however, six points were selected as postulated by the panel leader, who feels that the main goals should be:

1. To create a more accurately informed public understanding of State Mental Hospitals.
2. To guide laymen in securing psychiatric assistance for disturbed relatives and friends.
3. To encourage voluntary commitments.
4. To interest communities in developing their own local mental health resources.
5. To stimulate better legislation for mental health.
6. To recruit volunteers, both for the Center and for other allied agencies.

A questionnaire based on these points was therefore designed, (see APPENDIX B), and administered both to the subject audiences and to the subject panelists; the audiences being asked to rate each point according to their own interests, the panelists according to their estimate of the audience's interests. The material herewith presented is based upon the findings from the two.

It should be noticed, however, that two changes in the leader's original list were made, both inevitably affecting the results. The "recruiting of volunteers" was dropped, on the theory that while it might be a major point for the panel it was unlikely as a major advance concern for the audience. And "a chance to see your friends" was added, on the theory that the social gathering of the sponsor group in itself constituted a
magnet for member attendance. But how powerful a magnet? A secondary question for research became a comparison of the pull exerted by the program itself as against its social setting.
Objectives of the Audience as Estimated by the Panelists

The panelists, questioned on their expectations of the audience, uniformly objected to over-simplification. "Do you want me to say what I think they'd say, or what I think they'd think?" one asked, characteristically. They showed themselves highly sensitive not only to differences between audiences but also between individuals within the same group. Generalization, they implied, was ipso facto inaccurate. It was chiefly the desire to help out the author that finally overcame their mental reservations. Compiled, their opinion is herewith presented in tabular form.
TABLE II

OBJECTIVES OF THE AUDIENCE AS ESTIMATED BY THE PANELISTS

In each tabular column the upper figure represents the number of panelists who made this ranking; the lower (bracketted) figure represents their combined weight of ranking.

Rating weights were computed by giving six points to each 1st choice, five to each 2nd choice, and so on.

<table>
<thead>
<tr>
<th>Relative Rankings</th>
<th>1st Choice</th>
<th>2nd</th>
<th>3rd</th>
<th>4th</th>
<th>5th</th>
<th>6th</th>
<th>Total Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 To Understand Mental Hospitals</td>
<td>6 (36)</td>
<td>1 (5)</td>
<td>1 (4)</td>
<td>2 (5)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>51</td>
</tr>
<tr>
<td>2 To Help Relatives</td>
<td>2 (12)</td>
<td>2 (10)</td>
<td>1 (4)</td>
<td>3 (9)</td>
<td>2 (4)</td>
<td>0 (0)</td>
<td>39</td>
</tr>
<tr>
<td>3.5 To See Friends</td>
<td>2 (12)</td>
<td>1 (5)</td>
<td>1 (4)</td>
<td>3 (9)</td>
<td>1 (2)</td>
<td>2 (2)</td>
<td>34</td>
</tr>
<tr>
<td>3.5 To Help Community</td>
<td>0 (0)</td>
<td>3 (15)</td>
<td>2 (6)</td>
<td>1 (3)</td>
<td>4 (8)</td>
<td>0 (0)</td>
<td>34</td>
</tr>
<tr>
<td>4 To Know Oneself</td>
<td>0 (0)</td>
<td>3 (15)</td>
<td>3 (12)</td>
<td>0 (0)</td>
<td>1 (2)</td>
<td>3 (3)</td>
<td>31</td>
</tr>
<tr>
<td>5 To Help State</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>2 (16)</td>
<td>1 (3)</td>
<td>2 (4)</td>
<td>5 (5)</td>
<td>20</td>
</tr>
</tbody>
</table>
Collectively, it can be seen, the panel members believed that "To Understand Mental Hospitals" was to most of the audience of foremost interest, and that "To Help the State" was of least concern. Between these two extremes, however, a wide scatter of opinion becomes apparent.

"To Help Relatives" they put in second place, largely, they reported in personal conversation with the researcher, because of the great number of questions they invariably get on this point. But a tie exists in their minds as to whether the desire "To See Friends" or the desire "To Help the Community" ranks next in importance, indicating a split as to whether it is social activity or social action that provides the greater motivation.

"To Know Oneself" they rank next to the bottom of the scale.
Objectives of the Audience as Reported by its Members

The panelists were quite right, as it proved, in their estimate of greatest and least appeal. Every single one of the three subject audiences gave "To Understand Mental Hospitals" as their first reason for coming, and "To Help the State" as last.

TABLE III

OBJECTIVES OF THE TOTAL AUDIENCE AS REPORTED BY ITS MEMBERS

Weightings made as in TABLE II

<table>
<thead>
<tr>
<th>Relative Rankings</th>
<th>Total Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. To Understand Mental Hospitals</td>
<td>155</td>
</tr>
<tr>
<td>2. To See Friends</td>
<td>114</td>
</tr>
<tr>
<td>3. To Know Oneself</td>
<td>78</td>
</tr>
<tr>
<td>4. To Help Community</td>
<td>77</td>
</tr>
<tr>
<td>5. To Help Relatives</td>
<td>74</td>
</tr>
<tr>
<td>6. To Help State</td>
<td>10</td>
</tr>
</tbody>
</table>

"To Understand Mental Hospitals" was not merely the most popular reason for coming, it was overwhelmingly so. And "To Help the State" was not merely of little interest, it was almost nil.

Equally clear is the fact that the community ties of the sponsor organization do constitute a compelling reason for attendance. The audience quite frankly puts "To See Friends" in high second place.

The audience is, however, much more interested in the immediate and personal relevence of what is said than the panelists had anticipated. "To Know Oneself" they rank third, immediately after the conventional objectives of hearing the advertised program and entering into the social
occasion. They seem to be more interested, in other words, in psychiatric practice as a guide to inner understanding than as a guide to social action.

Social action was, however, of more interest to the Inter-Church Council, which included a number of clergy and professional men and women, than it was to the other two subject groups composed exclusively of women, housewives for the greater part, even though among them were a number of community leaders. The Council put "To Help the Community" at the top of their own group's list of objectives, - or at least they put it second only to the unanimously first place goal "To Understand Mental Hospitals." And this emphasis was again reflected in the fact that although they ranked "To See Friends" just after this, more than a dozen of the respondents added a note to the effect that this meant seeing their friends not as social acquaintances but as professional colleagues.

The wives of a fraternal order and the church women's auxiliary, on the other hand, both ranked "To Help the Community" down at the bottom of their list, only just above the universally minimized goal "To Help the State." Which would seem to mean that, despite the fact that both organizations are service oriented, their members think of this panel more as a source of help for themselves or their relatives than as a guide to community action.
Inferences

From these findings on objectives, several inferences may be drawn.

For one, the advance publicity given the panel by its sponsors would seem to be accurate. The audience knows that the program is to be about a state mental hospital, and they say that their primary reason for coming is to learn about just this.

For another, they also express an interest in each of the other five points that the panel plans to touch upon, with the single exception of social action on the state level. They do not indicate any special curiosity on any point other than those that the panel plans to cover. Given a chance to cite any other "Special Reason" for coming (See APPENDIX A), they listed none having to do with the content of the prospective program.

Advertised topic aside, the major magnet of the meeting emerges as the sponsor organization itself. Members candidly accord its social and community ties second place importance. From this it would further seem that the interest of the members in the panel is no stronger than their interest in their group. At the Church Women's Auxiliary, for instance, though the meeting was open to an inter-denominational public, there were no attenders other than the group's own members. In other words, the local prestige of the panel would seem to a large degree dependent on the local prestige of its sponsor.

When it comes to thinking of mental health in personal terms, the audience is more interested in how they can apply it in their own lives than in how they can use it to assist troubled relatives. This is contrary to the expectation of the panelists.

When it comes to social action, the audience had, as noted, almost no
interest at all in the state program, but considerably more in a local program. This the panelists anticipated accurately.

The audience in general, or at least those members who served as respondents, seem to be quite honest in their answers. More honest, in fact, than expected. The panelists in private conversation guessed that "To See Friends," for example, was actually an important reason for coming to the program, but felt that the audience would be reluctant to admit this. They also thought that "To Know Oneself" was an objective that the audience would minimize, preferring to present a more disinterested role. In fact, the audience admitted to both quite readily.
IV CHANGES IN ATTITUDE EFFECTED BY THE PANEL

The panel members, it will be remembered, speak with six objectives in mind, and really each is characterized by the fact that it deals essentially with an attitude. Among the audience, then, what actual change is effected in these attitudes as a result of the program presentation? Evidence of a change can be taken as key evidence of the general success of the panel.

To secure data on this, another questionnaire was designed (See APPENDIX C) and administered to the subject audiences once before the program began, to get their pre-existing opinions, then again afterwards, for the difference in their feeling. And, to obtain a comparison of expert with this lay opinion, the same questionnaire was administered to the ten panelists with a request that they give not their own attitudes but their expectation of audience attitudes.
Audience Attitudes and Attitude Changes as Expected by the Panelists

The panelists felt for the most part that the audiences would be preponderantly favorable on five of the six objectives, even before hearing the program. The exception was "Self Committal," and here they felt not only that a negative opinion would prevail, but that it would be unanimous. As to "change" they expected only improvement in the direction they sought, and varying with the various issues. (See TABLE IV)

TABLE IV

AUDIENCE ATTITUDES AND ATTITUDE CHANGES AS EXPECTED BY THE PANELISTS

<table>
<thead>
<tr>
<th>Attitude</th>
<th>Favorable</th>
<th>Unfavorable</th>
<th>Undecided</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Relative referral</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Before program</td>
<td>9</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>After program</td>
<td>9</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>2.5 Patient improvement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Before program</td>
<td>7</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>After program</td>
<td>9</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>2.5 Local resources</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Before program</td>
<td>7</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>After program</td>
<td>8</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>3.5 Legislative support</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Before program</td>
<td>5</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>After program</td>
<td>8</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>3.5 Voluntary work</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Before program</td>
<td>5</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>After program</td>
<td>8</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>4 Self committal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Before program</td>
<td>0</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>After program</td>
<td>4</td>
<td>2</td>
<td>4</td>
</tr>
</tbody>
</table>
On the first question, having to do with securing psychiatric advice for a disturbed relative, - which contains within it the implication of at least some general approval of psychiatry itself, - it will be noted that nine out of the ten panelists expected a positive sentiment. The tenth, a patient, based a "no" on her own impression that such approval is usually just lip service.

A majority of the speakers, seven out of ten, felt that the audience would certainly favor adequate local psychiatric resources. And again seven out of ten felt that they would expect to find a patient newly released from a mental hospital truly improved, on the grounds that "he wouldn't be released if he weren't."

The panelists were evenly divided among themselves, however, as to whether their listeners held a strong enough conviction about an adequate state mental health program to be willing to contribute to its actual costs. And another even split occurred among the speakers on the question as to whether or not the average audience member would like to do volunteer work for mental health.

On the general matter of "change", the panelists were particularly reluctant to make any guess that would imply measurement. One, who called himself a cynic, expected little if any change. His nine colleagues expected a good many changes but with no clear conviction as to extent or depth. "If something happens to just one person it's all worth while," one speaker insisted. "And something has happened, as a matter of fact, if you just fortify the people who are already friendly."
Audience Attitudes as Reported by the Audience Members Before the Program

The members of each audience who made up the respondent group did turn out to favor psychiatry in general and the work of mental health, as the experts had thought, but to an even greater extent. See below.

### TABLE V

| Audience Attitudes and Attitude Changes as Reported by the Audience Members |
| --- | --- | --- | --- | --- | --- | --- | --- |
|   | "Wives" | "Auxiliary" | "Inter Church" Ave. | Per Cent |
| 1 Relative Referral |
| Before | 95 | 0 | 5 | 96 | 4 | 0 | 100 | 0 | 0 | 97 | 1 | 2 |
| After | 95 | 0 | 5 | 96 | 4 | 0 | 100 | 0 | 0 | 97 | 1 | 2 |
| Change | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 2 Improved Patient |
| Before | 95 | 0 | 5 | 88 | 4 | 8 | 64 | 9 | 27 | 82 | 4 | 13 |
| After | 100 | 0 | 0 | 84 | 0 | 16 | 64 | 9 | 27 | 82 | 3 | 15 |
| Change | 5 | 0 | -5 | -4 | -4 | 8 | 0 | 0 | 0 | 0 | 0 | -1 |
| 3 Legislative Support |
| Before | 83 | 11 | 6 | 87 | 0 | 13 | 55 | 18 | 27 | 75 | 10 | 15 |
| After | 69 | 11 | 0 | 92 | 0 | 8 | 55 | 18 | 27 | 79 | 10 | 12 |
| Change | 6 | 0 | -6 | 5 | 0 | -5 | 0 | 0 | 0 | 4 | 0 | -3 |
| 4 Local Resources |
| Before | 66 | 17 | 17 | 57 | 0 | 43 | 64 | 18 | 18 | 62 | 12 | 26 |
| After | 72 | 11 | 17 | 70 | 0 | 30 | 55 | 9 | 36 | 66 | 7 | 28 |
| Change | 6 | -6 | 0 | 13 | 0 | -13 | -9 | -9 | 16 | 4 | -5 | 2 |
| 5 Self Committal |
| Before | 56 | 38 | 6 | 52 | 35 | 13 | 56 | 44 | 0 | 55 | 39 | 6 |
| After | 83 | 11 | 6 | 66 | 13 | 21 | 56 | 44 | 0 | 68 | 23 | 9 |
| Change | 27 | -27 | 0 | 14 | -22 | 8 | 0 | 0 | 0 | 13 | -15 | 3 |
| 6 Volunteer Work |
| Before | 33 | 23 | 44 | 48 | 13 | 39 | 43 | 0 | 57 | 41 | 12 | 47 |
| After | 46 | 17 | 37 | 57 | 8 | 35 | 56 | 0 | 44 | 53 | 8 | 39 |
| Change | 9 | -6 | -7 | 9 | -5 | -4 | 13 | 0 | -13 | 12 | 4 | -8 |
The most positive audience reaction, it can be seen, was for the use of psychiatry to assist troubled friends or relatives, and here even those who gave a negative response added an explanation (in their "open end" answers) that it was not psychiatry per se they objected to, only their own lack of qualification to know when and how to make a referral.

A markedly positive attitude was also expressed on two other points where more than half the panelists had expected it, i.e., an adequate local program and the expectation that a patient, once released, would be truly improved.

Surprisingly enough, however, they were far from as negative as the panelists had thought they would be on the matter of self committal. Instead of repudiating the whole idea, 55 per cent of the total respondents said they would be willing to enter a mental hospital voluntarily, "if necessary." And of those who expressed themselves as unwilling, a considerable number took pains to add fairly realistic explanations (again in their "open end" answers). "Not all of them are clean and well equipped," for instance, "I feel there would be a stigma attached," or "I would prefer private care if I had the means."

Finally, concerning both the last two points, - a tax increase and volunteer work, - half of the panelists, it will be remembered, expected a negative attitude and half a positive. In fact, this proved to be an underestimation for the first and an overestimation for the second. Three out of four of the respondents favored a tax increase if it could ensure a truly adequate state program. The rest in their "open end" answers indicated some confusion as to the issues at stake. "No need to build clinics," one said, "when there are already state hospitals." "Boston has enough, the rest of
the state can use these."

And only 41 per cent, or two out of five, audience members expressed any interest in doing volunteer work. This is worth a look. It turns out to be the only point of the six on which less than half of the respondents held a favorable point of view, the only attitude which was preponderantly negative.

Again from the "open end" answers it would seem that most of the audience interpreted the question on volunteer work to mean work within the hospital setting, even though the wording in no way limited it to this. And they further interpreted hospital work to mean work with patients, which they reported, they would dislike, some because they felt they would find it upsetting, others because they felt "inadequate".

Even their reluctance to work in a hospital is, however, surprising to the researcher. All three subject groups, by coincidence, lived near a large state hospital. The Wives of a Fraternal Order were known to include among their members several who do work regularly as volunteers at their own nearest hospital, also one member who is a registered nurse there. And the Church Women's Auxiliary must certainly have had many acquaintances also volunteering at their own nearest hospital, as considerable community effort had recently gone into a recruiting campaign for its assistance.
Audience Attitude Changes as Reported by the Audience Members Afterwards

To start with the preponderantly positive blocks: no change at all was reported in audience attitudes about psychiatry and its usefulness for troubled relatives. That had been almost completely favorable to begin with. As to developing an adequate local program, there was a four percent climb in those who appeared to think it more important after the talk than they had before. And, finally, on the expectation that a released patient would be in fact better, there was little shift. Only 17 percent were initially unfavorable or undecided on this point, to be sure, but the only gain effected was one percent who moved from negative to uncertain. In view of the fact that a released patient had just addressed them, and as a member of the panel, it would seem that the few who remain negative on this point constitute a hard core of inaccessibility.

To take up next the point on which the panelists had expected a strongly negative attitude, - voluntary self committal, - the audience, as noted, were, even before the program, not wholly opposed, more than half had been willing to accede, "if necessary." Yet, despite this open attitude, this was the point on which the single greatest gain was made. Fifty-five percent of the subjects responded positively to begin with, but another 13 percent joined them afterwards. It seems possible that the real effect of the patient panelist is shown just here.

Lastly, on the two points on which the panelists had had a division of expectation: when it came to an adequate state program, four percent more considered it worth a tax increase than had at the start. This would indicate at least some change in involvement, though hardly radical. And on the subject of volunteer work, where four out of ten had favored it
beforehand, five did later. Their "open end" answers still indicated some confusion, though, as to the practical possibilities. Asked what, specifically, they would like to do as volunteers, several put down "psychotherapy" or "psychotherapy with children," etc.
Inferences

The experts were correct in assuming a generally sympathetic lay attitude. More than half of the respondents were favorably inclined on every point the panel hoped to make even before its presentation, with the single exception of caring to engage in volunteer work for mental health. Their pre-disposition is most strikingly illustrated, indeed, in the question of voluntary admissions, where 55 per cent professed themselves as favoring it even for themselves and even before they heard what the panel had to say about state mental hospitals.

In the matter of attitude change, however, the greatest impact of the panel was found to be on this same point. After the presentation, an additional 13 per cent of the responding audience moved in the direction the speakers had hoped they would.

On three of the remaining six goals, positive movement was also evident, although to a lesser degree. Twelve per cent of the responding audience became more interested in volunteer work, and four per cent favored more support both for state and local programs.

On only two points did audience attitudes seem to remain static, recommending relatives to obtain psychiatric advice, and expecting to find a released patient actually better. On the first of these the audience attitude was already so positive that there was hardly room anyway for improvement; and on the second, eight out of ten respondents held positive expectations to begin with, though the fact that their number did not increase in the re-test must remain as one of the surprises of the findings.

The panel does, in summary, foster the attitudes it seeks to encourage and in the main succeed in avoiding the stimulation of any negative attitude.
Summary

The interdisciplinary panel of the Massachusetts Mental Health Center has just recently celebrated its tenth anniversary of activity in Eastern Massachusetts, educating interested local community groups on the work of the state mental hospitals and on mental health in general. A study of the effectiveness can contribute, it is hoped, not only to the future practice of the panel but also, in some small way, to the body of information now available on mental health education.

The panel seeks to secure both audience identification and audience participation. For the first, the leader opens with an estimation of the number of the immediate audience who may some day seek the care of a mental hospital. Then the experience of an actual patient are recounted, the program taking its structure from the presentation of his "case history," with each panelist speaking on the contribution of his own department in treatment and cure, - a psychiatrist, psychiatric nurse, psychiatric social worker, and an occupational therapist. Finally, in a "surprise appearance", the former patient himself takes the table, appealing to the audience for their support for yet other patients who will be returning to the community.

Audience participation is then encouraged in an open question period.

The audiences consist of pre-structured community groups who themselves initiate the invitation to the panel to give the program. From the present research project we now know that they, or at least their members who served as the respondents, are markedly sympathetic to psychiatry and the field of mental health. Their interest is, indeed, even greater than their speakers had so far estimated.
We also know now, however, that although the majority of the sponsor organizations are in principle service-oriented, their members are in fact more interested in the program as a guide to self-understanding than as a guide to social action. A large number of their questions to the panelists have to do with how they can obtain help for troubled friends or relatives, such a large number indeed, that the speakers had inferred this was one of the major concerns of the audience, but from the research questionnaires it is apparent that their real focus is more personal. They seem to be most interested in themselves: as persons, as members of the sponsor group, and as figures in the community.

Their honesty in admitting this in the research responses was far greater than either the author or the panelists had anticipated, and is best illustrated, perhaps, in the candor with which they say that a chance to see their friends at the program meeting is a major reason for coming. From the importance of the social values of the occasion it perhaps also follows that the panel is considerably dependent for its own local prestige on the local prestige of its sponsor organization.

In the area of social action, a paradox becomes apparent. Asked their attitudes on an issue such as an adequate state mental health program, they are all for it. Asked what they hope to learn from the panel, they express no interest in this at all. This can hardly be true in all cases; but, in general, they seemed to wish mental health well but to be lacking in a sense of personal involvement.

They are more interested in an adequate local program, to be sure, than they are in a state program. But asked about their interest in volunteer work at any level, their answers before the program begins indicate little
advance interest, and their answers after it is over show a greater sympathy but very little gain in an understanding of the practical possibilities. And this, too, presents a contradiction: it is the leader's impression that the panel often recruits volunteers with a very concrete sense of role.

Of the three subject groups, social action was, however, a much more genuine concern for the Inter-Church Council than for the wives of a Fraternal Order or the Church Women's Auxiliary. The present research project is not large enough in scope to discover what accounts for the difference, but the question is at least raised. Is it a matter of local interest? Or is it that groups of both men and women are more alert to social action than groups of women alone? Or is it a matter of professional composition?

Given a general friendly outlook towards psychiatric work for mental health, however, what is the capacity of these audiences for change, what degree of success has the panel in effecting it?

From the chapter on attitude change we know that change is most positive on the two points where at the start the attitudes were most negative, - self admission to a mental hospital, and volunteer work for mental health. Here the shifts were 13 per cent and 12 per cent respectively.

Change is also to be seen, though to a small extent, on the two points where the initial interest was also minimal, - support for an adequate community and an adequate state program. Here the gain was four per cent for each.

Movement is least on the two points for which the audience held the most favorable attitude at the start, - the general advisability of
psychiatric care, and the expectation that a mental hospital patient, once released, would be truly improved. On the first 29 out of 30 respondents were already convinced of its wisdom, so that the number open to influence was extremely small. On the expectation of patient improvement, 82 percent of the respondents held at the start that "he wouldn't be released if he weren't better;" after hearing the program there was a small movement from unfavorable opinion to "undecided;" but even with a patient as the final speaker on the panel there was little marked gain on the positive side.
Conclusions

One measure of success is certainly popularity. Evidence of the panel's popularity comes both from its own member speakers, who volunteer their services to continue its work, and from its audience, who extend more invitations than the panel can fill.

Another and better measure of success is effectiveness. The panel through its leader has selected six goals, six topics it hopes to clarify, each dealing not only with factual information, but also with an opinion or attitude. This attitude, where it is already favorable to mental health, the panel seeks to strengthen. Where it is unfavorable, they seek for change. From the research project the program is seen to have no negative effects; those of the audience who were favorable to begin with, remain so. Their positive attitudes have been offered confirmation and have probably been thereby strengthened. And where their attitudes were unfavorable, some change has been effected.
Recommendations

For other mental health agencies, the absence of unfavorable effects and the evidence of good effects make this panel safe and worthwhile, therefore valuable as a blueprint for allied educational efforts.

For the panel, the findings indicate that not all of its six objectives are equally well made, and that some re-evaluation of their number and weight might be tried. Specifically, to encourage communities to develop resources, the speakers may want to make more clear the differences between hospitals and clinics, and the fact that each is geographically limited in its service areas. To stimulate better legislation for mental health, they may want to make more clear the importance of the individual voter. And to recruit volunteers, they may want to spend even more time on the practical possibilities.

For future study, the author would like to recommend that seven further explorations would contribute to a fuller understanding of the panel and the effectiveness of its work:

1. An exploration of the structure and functions of the panel, as evolved, as they exist at present, and as they might develop further.

2. A study of the question: Are the responses of the present respondents truly representative of the opinions of the total audience?

3. A study of the audience reaction to the two "attention getters," i.e., the computation of the number of the audience who will at some point require hospitalization in a mental institution, and the surprise appearance of the patient as a speaker.

4. A study of the question: What sort of audience offers the best field for the panel? And how do "captive" audiences such as those studied here, each with pre-established purposes, compare with "non-captive" groups, assembled purely on the basis of special interest?
5. A study of the value of advance surveys of mental health conditions in the sponsor organizations' local community. Should presentations be individually adapted from area to area? How would the results compare with the results of the more standardized approach?

6. A follow-up study of the effectiveness of the panel in terms of social action.

7. A study to determine the duration of the effectiveness of the panel by means of re-testing, perhaps a week later, a month, six months, and a year.

Accepted.
David Landy
Research Advisor
BIBLIOGRAPHY
PUBLISHED MATERIAL

BOOKS

Briggs, L. Vernon, History of the Psychopathic Hospital, Boston, Mass.


Greenblatt, Milton, York and Brown, From Custodial to Therapeutic
Patient Care in Mental Hospitals, New York: Russell Sage
Foundation, 1955.

Jahoda, Marie, and others, Research Methods in Social Relations,


PERIODICALS AND REPORTS

Ewing, Oscar, The National Mental Health Program, U.S. Publication
No. 795293, Department of Health Education and Welfare,

Ridenour, Nina, "Criteria of Effectiveness in Mental Health Education,"

Stevenson, George S., "Ways of Developing and Utilizing Psychiatry in
Community Mental Health and Welfare Programs," Mental Hygiene,
24: 353-365, July, 1940.

INTERVIEWS

Cook, Esther, Chief, Social Service, Massachusetts Mental Health Center, Interview with the Author, Boston, March 14, 1958.

Ogilby, Anne, Head, House Social Service, Massachusetts Mental Health Center, Interview with the Author, March 2, 1958.
APPENDIX A
A comparison of expert and lay opinion was used, as noted in Chapter I, as the basis for data collection in this study, on the strength of the theory advanced by Nina Ridenour:

When educational material is consistently regarded as sound in the opinion of those best qualified to judge, and is well liked by the people for whom it is intended, it is probably good. Neither too little nor too much weight should be placed on these combined criteria. They do not give us an absolute answer, but they are a good guide.

Two questionnaires were therefore designed and pre-tested, the first for motivation, as described in Chapter III, the second for attitudes, as described in Chapter IV. A word on the thinking behind both, and on their final administration, should however be added here.

In the Motivation instrument (See APPENDIX B) seven possible reasons for attendance were set forth, five taken from the Panel leader's list of program objectives, the audience then asked to rate them all in order of preference.

The leader's sixth objective, the recruitment of volunteers, omitted, and an open invitation substituted instead to "jot down any other special reason that brought you." This, the author argued, would give a chance to indicate an interest in volunteer work, if that was in fact a reason for coming, but at the same time it would also give a chance to indicate any other reason that might not have been already mentioned.

In actual administration the audience did not use this for their hopes for the program content, only for data having to do with the meeting of the sponsor organization, such as "Came because I was invited by a

member," "Wouldn't want to miss a quarterly meeting of the Council,"
etc., so that in the end the data from this question were used in combina-
tion with those from the first question, having to do with "Seeing
Friends and Fellow Members."

In the attitude instrument (See APPENDIX C) a before-after test
technique was employed, for the reasons cited by Johoda, Deutsch and Cook
in their formulation of "controlled experiment" theory:

When a group is observed prior to its experimental
variable, then an experimental factor is introduced, and
when the group is observed again, then the difference in
the responses can be assumed to be a measure of the effect
of the experimental factor.13

The panel leader's six main points were taken again and converted
into statements giving the subjects a chance to check either a favorable
or an unfavorable attitude. An answer left blank was assumed to mean
"undecided." And the identical list was administered both prior to the
program and subsequently, the responses matched by an identifying number
for each individual respondent.

All six statements were also given with an open end, each respondent
having the chance here to jot down his reasons for his opinions should he
so desire. It was never planned to use these comments in any measurement
research, as it was anticipated they would be too various to make possible
any valid categorizations. They were added merely for what clues they
might provide the researcher as to what was going on in the minds of the
group members.

Several dangers are immediately apparent in the before-after tech-
nique.

13. Marie Johoda, and others, Research Methods in Social Relations,
p.65
The effects of the measurement process on the characteristic being measured constitutes a problem in all social research. If the people feel that they are 'guinea pigs' being experimented with, or if they feel they are being 'tested' and must make a good impression, or if the method of data collection suggests responses or stimulates an interest which the subject did not previously feel, the measuring process may distort the experimental results.

Although these influences may operate in any type of social research, the 'before-after' experiment is especially vulnerable. The 'before measuring' may crystallize an attitude; it may sensitize the respondents to the experimental variable so that they are more affected by it than they otherwise would be; it may exhaust the good will of the subjects. The second or 'after' experiment may introduce other problems; the subject may be bored and therefore unwilling to respond; or he may try to give responses which are consistent with his previous responses, thus minimizing the apparent change.14

And in addition to these, the immediate project presented a special complication in that it dealt with mental illness and mental health, topics which evoke emotional responses so deep that the subjects are stirred to protect themselves with mechanisms of defence, that unconsciously if not consciously, may affect their veracity.

To minimize as many of these distortions as possible three steps were taken: 1. Each respondent was guaranteed anonymity. 2. Each questionnaire was headed with a clear statement that nothing was involved of "right" or "wrong". 3. And at the time the "before" was given out, it was announced that there would be another questionnaire "after" but not that it would be identical.

In final administration, it will be noted that three different groups were measured for their reactions to the panel, but that the panelists were measured for their expectations of only one group, a theoretical and

unindividualized "audience." It is recognized that the speakers might have appraised each group somewhat differently, given the chance. They had no opportunity to see the groups or to get the "feel" of their individual attitudes, however, before they were actually ushered up to the auditorium table, so that it was mechanically impossible to ask them for any written advance opinion. And in any event they have evolved their program on the basis of a generalized impression.

None of the sponsor organizations could set aside special time for the administration of the questionnaires, their agendas were too full. The "motivation" and the "before" sheets were merely handed out to each group member as he entered the hall, then filled in while he waited for the program to begin. The only research introduction possible under the circumstances was a word of explanation mimeographed with the questions.

As to the "after" test, the panel leader announced its distribution from the head table and asked the audience's cooperation. Many of the audience by this time had, however, lost the identifying tags by which their "after" sheets could be matched to their "before." Without tags the questionnaires had to be discarded for research purposes. Except for this mechanical failure the number of respondents would have been about 33 per cent larger.
This is to ask your help in a student study for the Boston University School of Social Work, being made with the cooperation of the Massachusetts Mental Health Center, whereby it is hoped that more can be learned about citizens' interests in mental health.

You are not asked to sign your name. All answers will be anonymous.

Please just write a number (1) beside the line that comes nearest to giving the reason that brought you here, (2) beside the reason next nearest for you, and so on. Any that do not pertain at all, omit.

Then fold, for further anonymity. And please work fast because all questionnaires will be collected as soon as the meeting is called to order.

----------

DO YOU HOPE THAT THIS PROGRAM WILL..........

Give you a chance to see your friends and fellow members here in the sponsoring organization?

Guide you in working for a mental health program here in this community?

In this state?

Help you know yourself better?

Help you assist relatives or friends who may be upset?

Give you a better understanding of mental hospitals?

Or have you another special reason that brought you? If so, please jot it down here.
APPENDIX C
This is to ask your help in a student study for the Boston University School of Social Work, being made with the cooperation of the Massachusetts Mental Health Center, whereby it is hoped that more can be learned about citizens' interests in mental health.

You are not asked to sign your name. All answers will be anonymous.

Here below are listed six points commonly raised in any discussion about mental health:

Each point has two parts: first, a (positive) (negative) choice where you are asked to check the bracket that gives your own sentiment; second, an incomplete ending. Here just fill out with whatever phrase you find coming to mind spontaneously.

There is no "Right" or "Wrong" involved. No opinion need be explained in detail. When finished, please fold sheet and hold for collection.

If a relative of mine became mentally disturbed, I (would) (would not) recommend him to get psychiatric advice because

If I should become seriously ill mentally, I (would) (would not) want to go to a state mental hospital because

If an increase in my taxes were asked for the Mass. State Mental Health Program I would vote (yes) (no) because

If I heard it said that this township needs more psychiatric clinics, I would (agree) (disagree) because

If a neighbor of mine were just released from a state mental hospital, I (would) (would not) expect to find him really better because

If I had free time to give to a mental health program, the kind of volunteer job which I would most (like) (dislike) to do is