Responses to Nervous Breakdowns in America Over a 40-Year Period

Mental Health Policy Implications

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The 1957 and 1976 Americans View Their Mental Health surveys from the Institute of Social Research were partially replicated in the 1996 General Social Survey (GSS) to examine the policy implications of people's responses to feeling an impending nervous breakdown. Questions about problems in modern living were added to the GSS to provide a profile of the public's view of mental health problems. Results were compared for 1957, 1976, and 1996. In 1957, 19% of respondents had experienced an impending nervous breakdown; in 1996, 26% had had this experience. Between 1957 and 1996, participants increased their use of informal social supports, decreased their use of physicians, and increased their use of nonmedical mental health professionals. These findings support policies that strengthen informal support seeking and access to effective psychosocial treatments rather than current mental health reimbursement practices, which emphasize the role of primary care physicians.

Questions concerning the public's response to mental health problems have been informed in previous generations by the Americans View Their Mental Health (AVTMH) surveys. In both 1957 and 1976, these surveys provided directions and benchmarks for national mental health policy (Gurin, Veroff, & Feld, 1960; Kulka, Veroff, & Douvan, 1979; Veroff, 1981; Veroff, Kulka, & Douvan, 1981). The replication of some of the AVTMH questions in the General Social Survey (GSS) of 1996 provided a further opportunity to clarify and direct policy for mental health services. Specifically, it provided information on how Americans today are interpreting and responding to mental health problems and how these reactions have changed relative to the past two surveys.

Mental Health Themes Over the Past 40 Years

Professional and self-help resources for problems of mental health were few in 1957. The ability of professionals to recognize, diagnose, and treat mental health problems was limited, and their ideas about coping and help seeking were mostly theoretical (Cowen, Gardner, & Zax, 1967). Community mental health center legislation in the 1960s represented an attempt to remedy these problems with goals of destigmatizing mental illness through educational campaigns, encouraging professional help seeking, and developing new interventions (Joint Commission on Mental Illness and Health, 1961). Professional resources became more available through a nationwide federal initiative to support community mental health centers, staffing grants, and expanded professional training opportunities (Chu & Trotter, 1974). Also, treatment advances, such as the de-

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This study was funded by a MacArthur Foundation grant, by Grants MH51669 and RO1 MH49086-01A3 from the National Institute of Mental Health, and by Grants SDR 95-002 and MPC 97-0010 from the Health Services Research and Development Service of the Department of Veterans Affairs. Interviews were conducted by the staff of the National Opinion Research Center and were funded by Grant SBR-9122462 from the sociology program at the National Science Foundation.

Our thanks to Thomas Smith of the National Opinion Research Center for managing the interviews and the initial data compilation and to Terry White of the Indiana Consortium for Mental Health Services Research for coordinating data coding. We thank Joseph Veroff, Elizabeth Douvan, and Toni Antonucci of the Institute of Social Research at the University of Michigan for their generous support and assistance in extending their original survey to a partial 40-year follow-up. A special thanks to J. Scott Long for his gracious statistical guidance. Teresa Damush, Jaya Rao, and Morris Weinberger provided helpful comments on earlier versions of this article.

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0003-066X/00/$5.00
Vol. 55, No. 7, 740–749 DOI: 10.1037//0003-066X.55.7.740

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velopment of effective psychotherapies and pharmacotherapies, were fueled by the expansion of basic research (Kopta, Lueger, Saunders, & Howard, 1999; Nathan & Gorman, 1998; Russell & Orlinsky, 1996; Seligman, 1994; Thase & Kupfer, 1996).

In contrast, preventing mental health problems by helping people develop more adaptive coping strategies and by using informal caregiving resources has been a developing but minor subtheme of the public mental health debate (Caplan, 1964; Felner, Jason, Moritsugu, & Farber, 1983; Price, Ketterer, Bader, & Monahan, 1980). Only in recent years has prevention research actually demonstrated that greater coping skills and the development of self-help and indigenous support for individuals are important building blocks for national mental health policy (Institute of Medicine, 1994; Muehrer, 1997; Sandler, 1997). In light of these advances, an important challenge today is bridging the conceptual gap between the emerging prevention field and the long-standing treatment field, with its emphasis on already existing mental health problems. To meet this challenge, it will be necessary to have accurate data on the public's relative preferences for professional treatment on the one hand and self-help and indigenous support on the other.

The AVTMH Studies and the 1996 GSS

The 1957 and 1976 AVTMH studies were landmarks in defining mental health policy. The 1957 study asked hundreds of mental health and lifestyle questions. These revealed that significant numbers of Americans perceived their problems in psychological terms and that they were willing to seek help for them from both clergy and physicians. The results of the 1957 study also provided empirical underpinnings for the mental health education and training movements of the 1960s. As one report stated,

> AVTMH thus indicates the potential value of attempts to reach more people and different classes of people with mental health information. But the recognition of this fact merely begs the question of where we will get the manpower to meet increased demand for mental health services. (Joint Commission on Mental Illness and Health, 1961, p. 108)

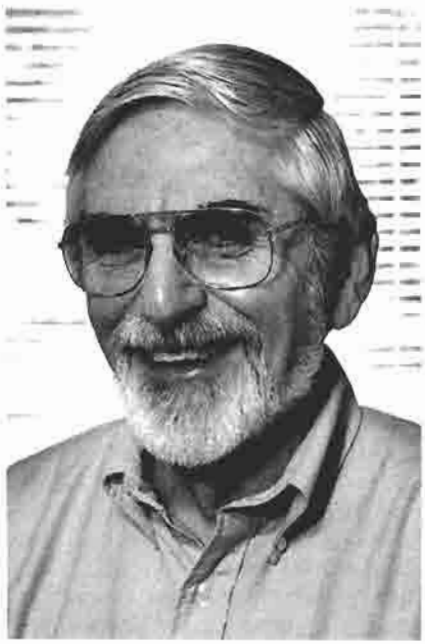
The 1976 study revealed an acceleration in these trends, with researchers concluding, among other things, that "people who in 1976 reported having felt an impending nervous breakdown were much more likely than people who reported such feelings in 1957 to accept the possibility that they might have a problem that would require professional help" (Veroff et al., 1981, p. 85).

The 1996 survey offered a unique opportunity to assess the prevalence of these feelings for the current generation and to examine how people's responses to them have changed over the past 40 years. In turn, these results should help inform current mental health policy. This seems especially important today for two reasons. First, epidemiological evidence shows that rates of mental disorders such as depression are on the rise (Klerman & Weissman, 1989), which suggests an increased need for services. Second, recent studies have found that only 40% of Americans with a diagnosable disorder have ever received any formal care, and that only 25% of those with a disorder received care from mental health specialists (Kessler et al., 1994). Both these findings suggest that understanding how individuals are managing their mental health problems is as important today as it was in 1957 and 1976. Specifically, how are individuals coping with the feeling of an impending nervous breakdown, and what might be the role of informal sources of help? Only longitudinal or panel data, such as those reported here, can answer these types of questions.

As such, this article examines the following public health questions: Is the current generation of Americans experiencing a greater sense of impending nervous breakdown than did the previous two generations? Have the reasons underlying the experience of impending nervous breakdown changed over the past 40 years? Are sources of mental health problems more or less conducive to formal help seeking? What differences are there, if any, in how Americans of the current generation are dealing with impending nervous breakdowns compared with the previous two generations? Specifically, is the current generation more likely to seek professional help and receive medications? What does the term *nervous breakdown* mean to the current generation when compared with more modern terms such as *mental illness*?

Method

Questions asked in the 1956 and 1976 AVTMH national surveys, together with demographic information from the present 1996 GSS, provided the basis for this particular study. The GSS was an in-person, 1.5-hour interview conducted by the National Opinion Research Center of the University of Chicago. The GSS, funded primarily by the



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National Science Foundation, used a cluster sampling design to provide a nationwide, representative sample of adults living in noninstitutionalized settings. The response rate was 76.1%. The 1996 survey included a number of topical modules. The focus of the mental health module in this survey, the Problems in Modern Living module, was designed to provide a current profile of the public's view of mental health problems. This portion took about 20 minutes of the full GSS interview.

Respondents

A total of 1,444 respondents were surveyed in 1996 and asked the target question of whether they had ever thought they were having a nervous breakdown. Despite its crudeness as an indicator, the term *nervous breakdown* has a resonance with the public and, of several subjective mental health measures, bore the strongest relationship to help seeking in the 1976 study. In 1957 and 1976, the sample sizes were 2,460 and 2,264, respectively. Given the changes that have taken place in the composition of the American adult population over the past 40 years (as noted in other surveys), it is not surprising that there were statistically significant differences in the characteristics of the samples. The 1996 sample had a higher family income and was more racially diverse. Participants also tended to be non-Protestant, suburban, nonrural, better educated, less likely to be married, and less likely to profess any religious preference (all differences were significant; $p < .001$[1]). It was therefore important to control for these changes.

Data

The mental health module of the GSS was organized into a series of submodules. The demographic variables used in this study included race (*White* = 0, *non-White* = 1), sex (*male* = 0, *female* = 1), age (18–39 years, 40–59 years, 60+ years), religion (Protestant, Catholic, Jewish/other, none), housing location (urban, suburban, rural), education (less than high school graduate, high school graduate, some college, college graduate and higher), marital status (married, never married, divorced/separated/widowed), reported annual family income (in thousands of dollars), and having children (*no* = 0, *yes* = 1). To control for inflation in comparative logistic analyses, annual family income was z transformed using the mean and standard deviation of the cohort year of the respondent. Thus, 1957 incomes were z transformed using the 1957 mean and standard deviation, and the same was done for the 1976 and 1996 cohorts.

The first half of the Problems in Modern Living module provided respondents with a descriptive case vignette about which questions were asked. After the vignette portion of the module, half of the sample was asked, "Of course, everybody hears a good deal about physical illness and disease, but now, what about ones we call mental or nervous illness? As far as you know, what is a nervous breakdown?" (with the following probes: "How would you describe it?" "What is it like?" "What happens to a person who has one?" "How does he act?"). Each person's responses were coded into up to three diagnostic categories and up to three symptoms or manifestations (represented as "Nervous breakdown" in Table 3).

The other half of the respondents were asked the same lead-in question, "Of course, everybody hears a good deal about physical illness and disease, but now, what about ones we call mental or nervous illness?" followed by, "When you hear someone say that a person is 'mentally ill,' what does that mean to you?" (with the following probes: "How would you describe a person who is mentally ill?" "What do you think a mentally ill person is like?" "What does a person like this do that tells you he is mentally ill?" "How does a person like this act?"). Each person's responses were coded into the same diagnostic and symptom–manifestation categories used for the nervous breakdown question (represented as "Mental illness" in Table 3).

After a few questions about the respondent's knowledge of other people's use of mental health services or of people who were hospitalized because of a mental illness, the full sample was asked, "Have you ever felt that you were going to have a nervous breakdown?" (*yes* = 1, *no* or *don't know* = 0). This is the same question asked in the 1957 and 1976 AVTMH studies. If respondents answered "yes," they were then asked the remaining questions that formed the basis for this study: "Could you tell me about when you felt that way?" "What was it about?" From responses to this latter question, up to three external precipitating factors perceived by respondents to be related to the nervous breakdown were coded. The categories were as follows: own health problem, social network events, others' health problems, work or school problems, financial problems, and housing problems. A respondent could re-

[1]These analyses are not shown but are available from Ralph Swindle, Jr., on request.

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Photo by Jerry Mitchell

port multiple precipitating factors for the nervous breakdown. Explanations that were likely to be synonymous for an impending nervous breakdown, such as stress, depression, self-doubt, and personal adjustment problems, were excluded as factors to avoid obvious confounding.

Those who responded in the affirmative to the nervous breakdown question were then asked, "What did you do about it?" (the probe "Anything else?" was repeated until the respondent said "no"), and then they were asked, "Which of these things did you do first . . . second . . . third . . . ?" Answers to the former question provided information about coping and help seeking in response to an impending nervous breakdown. As suggested by the coping theory of Moos (Moos & Schaefer, 1993), coping and help seeking responses were coded as approach coping responses (1 = *any use of logical analysis, positive reappraisal, or problem solving;* 0 = *no mention of any of the three approach coping responses*), avoidance responses (1 = *combining any use of cognitive avoidance, alternative rewards, emotional discharge, and doing nothing;* 0 = *no mention of any of the avoidant coping responses*), informal support seeking (1 = *seeking of any friends, family, or self-help groups to deal with the nervous breakdown;* 0 = *no mention of informal support seeking*), or formal support seeking (1 = *any seeking of primary care physicians, psychiatrists, counselors, mental health specialists, etc.;* 0 = *no mention of formal support seeking*).

Each respondent could have as many as three coping responses and three help sources coded. If more were provided, the interviewer chose the first three in the order in which they occurred, with the first being the most immediate response following the feeling of an impending nervous breakdown. The extensive coding manual, category descriptions, and interrater reliabilities are available from Bernice Pescosolido. Finally, respondents who said they had never felt they were going to have a nervous breakdown or did not know were asked, "Have you ever felt you had a mental health problem?" (*yes* = 1, *no* = 0, *don't know* = 8).

Original complete respondent protocols for the 1957 and 1976 surveys were obtained from the Institute of Social Research, University of Michigan, where the original researchers provided permission to reuse the items and gave guidance on coding. All data from 1957, 1976, and 1996 were recoded into categories developed by the original AVTMH researchers. Master's-level staff at Indiana University were trained to provide consistent coding of responses. Using the categories from the earlier studies reduced the possibility that the temporal changes would be due to cultural differences in the understanding and interpretation of responses by the coders for each of the three study years.

Data Analyses

Simple cross-tabulations were used to present, for the three study years, the distribution of respondents' answers to the following questions: Had they ever experienced a nervous breakdown or a mental health problem? What were the perceived precipitating factors for the impending nervous breakdown, and how was it handled? Likelihood-ratio chi-square tests provided an indication of whether reports varied over time to a statistically significant degree. Data from 1996 concerning individuals' endorsement of having had a mental health problem at some point are reported as simple frequencies.

Logistic regression was used to determine the extent to which changes over time could be attributed to year, to demographic differences, and, where appropriate, to changes in the perceived precipitating factors of impending nervous breakdowns. Changes in rates of reported nervous breakdowns over the three study years are reported with both unadjusted (crude) prevalence rates and adjusted rates, using the procedure described by Long (1997). Other results for year differences include unadjusted prevalence rates, along with the chi-square adjusted by the pooled logistic regression (of the form shown in the "Pooled" column of Table 1). Omitted variables in dummy coding in the logistic regressions were for the age 60+ years, education status of college graduate and higher, married status, no religion, an urban housing location, and the year 1996.

Responses to an impending nervous breakdown were examined using logistic regression to control for demographic changes (Table 1) and perceived precipitating factors (not shown in tables). Because physicians can prescribe medication, changes in use of medication were evaluated only for those respondents who sought a physician.[2]

Finally, synonyms used in describing the meaning and symptoms of a nervous breakdown were compared with

[2] Psychiatrists were analyzed separately because of their absence in the 1957 sample and their low number (n = 13) in 1996. Their medication use paralleled that of physicians.

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those used for mental illness, using forward-entry logistic regression and described with cross-tabulations. The adjectives selected for analysis were endorsed by at least 4% of respondents in either subgroup. Forward entry was used to demonstrate overall discrimination between the concepts and to control for significant differences due to highly similar adjectives or the number of univariate tests. Unless otherwise specified, because of the large number of participants, all analyses used a $p < .001$ level of significance to identify only the most meaningful effects.

Results

Results from the GSS are presented in terms of the specific questions outlined above and in that order. Also, to test the adjusted significance of yearly differences over time, we used pooled logistic regression to control for the demographic changes reported in Table 1.

Impending Nervous Breakdowns

Significantly more Americans reported feeling an impending nervous breakdown in 1996 than in 1957 or 1976. The endorsement of the nervous breakdown question increased from 18.9% in 1957, to 20.9% in 1976, to 26.4% in 1996, $\chi^2(9, N = 1{,}302) = 30.05$, $p < .0001$, with the largest increase occurring in the past 20 years. To account for changes in demographic factors, adjusted prevalence rates were calculated using the result of logistic regression for each year (Long, 1997). The adjusted prevalence rates for persons with average characteristics are 17.0% in 1957, 19.6% in 1976, and 24.3% in 1996, which still represents a progressive increase over the past 40 years. Demographic factors that consistently increased the likelihood of reporting an impending nervous breakdown over the three study years were being White, being a woman, having no religion, having less family income, being younger, having children, and not being married (see Table 1).

Recall that those who responded that they had never experienced an impending nervous breakdown were asked the follow-up question, "Have you ever had a mental health problem?" (which was not done in the AVTMH surveys). This added another 7% to the number of individuals reporting a mental health concern, such that about one third of all American adults surveyed in 1996 admitted to having felt at some point either that they were going to have a nervous breakdown or that they had had a mental health problem.

Perceived Precipitating Factors of Impending Nervous Breakdowns

Next, we examined the responses of individuals who reported having felt an impending nervous breakdown. All data represent unadjusted prevalence rates. Also, to test the adjusted significance of yearly differences over time, we used pooled logistic regression to control for the demographic changes reported in Table 1.

Americans who felt they were going to have nervous breakdowns over the three survey years had somewhat different explanations for these feelings (see top of Table 2). The most consistent trend was for the category of participants' own health problems, which were less likely to be given as an explanation in later surveys. Although events affecting loved ones (i.e., network events) did not significantly change from 1976 to 1996, they remained highly prevalent as explanations. In 1996, the most frequently cited network events related to impending nervous breakdowns were divorce, marital strains, marital separation, and troubles with members of the opposite sex. Work and educational problems as precipitating factors were also generally stable over time and most commonly represented tension in the work site and course load pressures. The unadjusted prevalence of financial precipitating factors, such as not having enough income or loss of income, increased over time but did not increase in the pooled demographic analysis when family income (as a collinear factor) was controlled. Housing precipitating factors were lowest in prevalence and were essentially stable over time; these most often reflected relocation or other difficulties related to one's residence.

Responses to Impending Nervous Breakdowns

There was only one overall change in participants' responses to impending nervous breakdowns, namely, the use of informal supports (see the middle of Table 2). Demographic controls for changes over time made no difference in this finding. Reliance on informal supports, such as family and friends, showed a strong increase over the past 20 years. Seeking formal sources of help remained essentially unchanged in overall percentage, remaining the dominant response to an impending nervous breakdown. There was no evidence of changes in reported use of approach or avoidant coping responses.

Within the category of formal support advisors (see the bottom of Table 2), there have been some major changes. The

role of physicians in helping with an impending nervous breakdown declined dramatically, from 44% in 1957 to 18% in 1996; also, between 1976 and 1996, seeing a psychiatrist declined from 8% to 3%. By contrast, there was a total increase in seeking the services of counselors, social workers, and psychologists, from 0.6% in 1957 to 18% in 1996. For those individuals who saw a physician for an impending nervous breakdown, there was a significant increase in the use of medications, from about 34.5% in the first two study years to about 57% in 1996 (see Table 2).

To assess whether there was a match between precipitants and responses, we added demographic (Table 1) and perceived precipitating factors (top of Table 2) to the predictive model (Cutrona & Russell, 1990). When this was done, controls for demographic factors and perceived sources of breakdown did not affect the observed rise in individuals' choice of informal support as a coping response. However, we did find that younger age was associated with a greater tendency to seek family and friends for informal support. Formal support seeking occurred most often with individuals who saw their feelings of breakdown as health related. Americans who viewed their feelings of breakdown as related to financial, job, or educational difficulties were, however, less likely to seek formal help. Finally, in terms of a formal advisor, being a woman and seeing the nervous breakdown as related to health problems were predictive of seeing a physician, whereas being divorced, widowed, or separated was a predictor of seeking help from nonmedical professionals.

Nervous Breakdowns and Mental Illness

A final issue in this study is the meaning of the term *nervous breakdown* as compared with other terms such as *mental illness*. This issue was not addressed in the 1957 or 1976 surveys. In 1996, half of the respondents were asked to describe the characteristics of a mentally ill person, and the other half were asked to describe a nervous breakdown (see Table 3). In the public mind in 1996, nervous breakdowns corresponded to neurotic and mood disorders, whereas mental illnesses corresponded to more serious psychotic disorders, along with socially deviant and violent behavior. We have no way of knowing whether this was also true in 1957 and 1976,

Table 1
Logistic Regression of All Characteristics Affecting the Experience of Nervous Breakdown by Year

	1957		1976		1996		Pooled	
Characteristic	*b*	*SE*	*b*	*SE*	*b*	*SE*	*b*	*SE*
Non-White	−.07	.20	−.37	.17	−.44	.18	−.34**	.10
Female	.92**	.12	.66**	.12	.71**	.14	.73**	.07
Religion								
Protestant	.06	.42	−.13	.19	−.45	.20	−.28	.13
Catholic	−.07	.43	−.44	.21	−.44	.22	−.45**	.14
Jewish/other	.27	.49	.66	.25	−.19	.29	.21	.17
Residence								
Suburban	.05	.16	.15	.13	−.05	.16	.09	.08
Rural	.34	.13	.11	.14	−.11	.25	.19	.09
Education								
Less than high school	.30	.23	.26	.19	.43	.24	.32	.12
High school graduate	−.09	.24	.04	.17	.26	.17	.07	.11
Some college	.17	.27	.02	.19	.29	.27	.14	.13
Family income (*z* transformed)	−.06	.07	−.14	.07	−.32**	.07	−.17**	.04
Age								
20–39 years	.65**	.18	.96**	.17	1.12**	.22	.93**	.10
40–59 years	.64**	.17	.62**	.17	1.23**	.21	.82**	.10
Have children	.70**	.19	.33	.18	−.05	.17	.34**	.10
Marital status								
Divorced/widowed/separated	.14	.16	.40	.14	.62**	.16	.41**	.09
Never married	.54	.30	.32	.24	.22	.21	.37	.13
Year								
1957							−.49**	.10
1976							−.32**	.09
Intercept	−3.53		−2.79		−2.38		−2.51	
χ^2 [a]	123.1		111.37		130.31		344.36	
N	2,345		2,236		1,411		5,992	

[a] Significance value for all chi-square tests is $p < .001$.
** $p < .001$.

because comparisons between nervous breakdowns and mental illnesses were not made in the earlier surveys.

Discussion

We found that more Americans had at some point felt an impending nervous breakdown in 1996 than in 1957 or 1976. This finding cannot be accounted for by demographic changes and suggests either a change in the prevalence of psychological problems or a lessening of the stigma associated with admitting that one is going to have a nervous breakdown (or both).[3]

We also found some changes in the reasons Americans gave for feeling they were going to have a nervous breakdown. Explanations related to health declined, those related to events affecting significant others continued to be high from 1976 to 1996, and those related to external events remained common. Because health events appear to be a less common explanation for feeling an impending nervous breakdown, mental health problems today appear to be less conducive to formal medical help seeking than

Table 2
Unadjusted Yearly Prevalence Rates (in Percentages) for Precipitants, Coping Responses, and Formal Advisors for Respondents Reporting Nervous Breakdowns in the 1957 and 1976 Americans View Their Mental Health (AVTMH) Surveys and the 1996 General Social Survey (GSS)

Participants' responses	1957	1976	1996	χ^2	Logit. Adj. χ^2
Precipitants					
Own health	28.1	12.2	5.6	70.60**	24.65***
Financial	4.6	4.5	11.0	15.06**	*ns*
Network events	10.4	30.2	24.2	46.92**	21.34***
Work/school	13.8	17.9	17.1	*ns*	*ns*
Others' health	5.8	5.9	3.9	*ns*	*ns*
Housing	3.4	1.1	3.7	6.80	*ns*
Coping response					
Approach	12.5	20.1	31.6	46.16**	*ns*
Avoidance	27.8	24.4	29.0	*ns*	*ns*
Informal support	6.5	12.4	28.3	66.42**	40.83**
Formal support	48.1	49.8	42.0	*ns*	*ns*
Formal advisor					
Medical doctor	44.4	31.1	17.9	58.30**	19.06**
Medications[a]	34.7	34.3	56.9	11.21*	11.03*
Nurse	4.6	6.7	4.4	*ns*	*ns*
Psychiatrist	0.0	8.0	3.6	41.02**	33.74**
Psychologist	0.0	0.0	2.7	*ns*	*ns*
Counselor	0.6	3.8	15.4	71.25**	37.54**
Mental hospital	0.6	3.3	3.3	*ns*	*ns*

Note. For the 1957 AVTMH, $N = 327$ for precipitants and 324 for coping response and formal advisor. For the 1976 AVTMH, $N = 441$ for precipitants and 450 for coping response and formal advisor. For the 1996 GSS, $N = 356$ for precipitants and 364 for coping response and formal advisor. Logit. Adj. χ^2 = χ^2 associated with the pooled hierarchical logistic regression step increase for the years 1957 and 1976 after controlling for race, sex, age, marital status, having children, religion, urbanization, education, and z transformed family income.
[a] Because only 349 respondents reported seeing a physician for their nervous breakdown, the $p < .01$ level is reported.
* $p < .01$. ** $p < .001$.

Table 3
Forward-Entry Logistic Regression Predictors of Nervous Breakdown Versus Mental Illness With Frequencies of Meanings and Symptoms

	Nervous breakdown		Mental illness	
Respondents' descriptions	*N*	%	*N*	%
Included in regression[a]				
Nervous breakdown				
Neurosis	422	65.0	160	25.5**
No control of self	126	19.4	42	6.0**
Unable to function in life	93	14.3	36	5.5**
Anxious	84	12.9	20	3.0**
Mental illness				
Disordered/abnormal	28	4.3	147	22.5**
Functionally impaired	54	8.3	100	15.3**
Mental deficiency	7	1.0	90	13.8**
Socially deviant	5	0.7	69	10.6**
Violent psychosis	35	5.4	64	9.8**
Not included in regression[a]				
Nervous breakdown				
Not adjusting to life	218	33.6	71	10.9**
Neurasthenia	127	19.5	72	11.0**
Depression	95	14.6	37	5.7**
Withdrawn	41	6.3	27	4.1
Weeping	31	4.8	3	0.5**
Defeated	31	4.8	2	0.3**
Mental illness				
Other psychopathology	68	10.5	123	18.8
Psychosis	38	5.8	107	16.4**
Irrational	70	10.8	83	12.7
Nonviolent psychosis	35	5.4	64	9.8
Retarded	2	0.3	62	9.5**
Violent	13	2.0	58	8.8**
Unstable	55	8.5	49	7.5
Suicidal	26	4.0	41	6.2
Impaired judgment	28	4.3	39	5.0

Note. Half of the respondents were asked to describe the characteristics of a mentally ill person ($N = 653$), and the other half were asked to describe a nervous breakdown ($N = 649$). Thus, this is an independent, between-group comparison. The percentages are percentages of respondents naming a synonym in that category for meanings of *nervous breakdown* or *mental illness*. For example, 65% of respondents came up with the synonym of *neurosis* for *nervous breakdown*, whereas only 25.5% came up with *neurosis* as a synonym for *mental illness*. In contrast, 22.5% came up with *disordered/abnormal* as a synonym for *mental illness*, whereas only 4.3% came up with that for *nervous breakdown*.
[a] Refers to descriptions included or not included in the forward-entry logistic regression model, $\chi^2(9) = 524.08$** with the $p < .001$ inclusion level, logistic intercept = −.34.
** Univariate χ^2 $p < .001$.

[3] See, however, Phelan, Link, Stueve, and Pescosolido (1996) and Link, Phelan, Bresnahan, Stueve, and Pescosolido (1999), who suggested that stigma for more severe mental illness may have increased.

those of 20 and 40 years ago. That is, it makes less sense to go to a primary care physician if the problem is not seen as precipitated by a health concern.

Americans today appear to be more oriented toward dealing with their feelings of impending nervous breakdowns through informal supports from family and friends, combined with an increased use of nonmedical professionals, such as counselors, social workers, and psychologists. These findings cannot be fully attributed to demographic changes or to differences in reasons attributed for having the feelings of an impending nervous breakdown. It does appear, however, that nonmedical professionals are increasingly sought in response to network events by both younger and divorced (or separated) respondents.

Finally, with the rise of new medications and new medical care reimbursement policies, we expected more Americans to have consulted a primary care physician for medication or to have used this as an entry point to obtain reimbursable mental health specialty care. However, relative to both 1957 and 1976, there was a decline in 1996 in the percentage of Americans seeking a physician as an aid in coping with feelings of a nervous breakdown.

Policy Implications

A goal of American mental health educational policy over the past 40 years has been to normalize mental disorders so that the public would seek treatment for psychological distress as easily as they do for physical illnesses (Joint Commission on Mental Illness and Health, 1961). A second goal has been to increase the supply of mental health specialists who could meet the anticipated increased demand for mental health services (Joint Commission on Mental Illness and Health, 1961). The results of this study suggest some progress has been made toward these goals, at least for less severe mental health problems. Americans appear to be more willing to admit to having feelings of an impending nervous breakdown than they were 40 years ago, and nonmedical mental health specialists are increasingly seen as appropriate resources for these problems.

Despite the latter trend, a variety of mental health reimbursement models have emerged in recent years, many of which emphasize a role for primary care physicians as mental health providers.[4] It is estimated that as many as 162 million Americans were covered under some form of managed care contract by the end of 1998 (Sturm, 1999). For mental conditions, this often entails having a primary care physician as the initial provider of mental health care for the kinds of problems likely to be considered nervous breakdowns (Depression Guideline Panel, 1993; Katon & Gonzales, 1994). It seems somewhat ironic to us that although the public appears more accepting of mental health services from nonmedical providers, they may have to access services through physicians, who they see as less appropriate sources of help for mental health problems.

A second recent development involves research on empirically supported psychological and pharmacological treatments. Efficacious treatments are now available for many of the mood and anxiety disorders that would fit within the rubric of nervous breakdown (Barlow & Lehman, 1996; Beutler, Kim, Davison, Karno, & Fisher, 1996; Christensen & Heavey, 1999; Hollon, 1996; Mynors-Wallis, Davies, Gray, Barbour, & Gath, 1997; Nathan & Gorman, 1998; Seligman, 1994; Thase & Kupfer, 1996). Brief psychotherapies are particularly appropriate for these less severe problems (Munoz et al., 1995). Unfortunately, these promising procedures are not widely disseminated to the public at large and are still rarely used in many applied settings (Hollon, 1996; Task Force on Promotion and Dissemination of Psychological Procedures, 1995). A further problem is that physicians are not likely to be aware of these developments either. They tend to dramatically underdiagnose psychological disorders (deGruy, 1996; Goldberg, 1995; Klinkman & Okkes, 1998) and are reluctant to make referrals voluntarily for psychological treatment.

Finally, we believe that a mental health policy emphasis that is prevention centered—focused on building coping skills, fostering stress resilience, and strengthening ties with family and friends—is in keeping with the present results (Institute of Medicine, 1994; Muehrer, 1997; Sandler, 1997). Self-help and seeking indigenous support are becoming increasingly common responses to feelings of impending breakdown. The National Institute of Mental Health's emphasis on primary prevention appears timely and in step with a considerable portion of the public that turns to community-based nonprofessional help providers (Kolbe, 1997; Reiss & Price, 1996).

Study Limitations

When considering these findings overall, it is important to stress that they speak to a concept of nervous breakdown that is considered a less serious condition than mental illness. Our findings are consistent with those of Pescosolido, Monahan, Link, Stueve, and Kikusawa (1999), who found that Americans make distinctions among disorders, with disorders such as depression and anxiety considered much less serious conditions than schizophrenia. Thus, we think these findings may be generalized only to the milder end of the spectrum of mental health problems and help-seeking preferences. Moreover, although asking about nervous breakdowns may have made sense in 1957 given the methods of the day, it is suspect in the light of 1996's structured diagnostic interviews and sophisticated symptom scales. Single-item scales are prone to a variety of interpretations, and this one question bears a huge burden in this study.

Another worrisome issue is whether the meanings of the words and responses to the questions have changed over the past 40 years. However, by having all responses recoded in 1996 by the same raters, we attempted to reduce

[4] There have been calls for movement toward collaborative care models that directly integrate mental health specialists into clinical practices. Proponents of this movement believe that this is a valuable and cost-effective direction for managed care (Katon & Gonzales, 1994; Katon et al., 1995, 1999; Kim & Flaherty, 1997; Klinkman & Okkes, 1998; Lin et al., 1997; Meredith et al., 1999; Mynors-Wallis et al., 1997; Wells & Sturm, 1996; Wells, Sturm, Sherbourne, & Meredith, 1996). However, thus far these models have not been replicated or disseminated.

the possibility that differences in the results could be due to differences in the coding systems for the three study years. Further, we consulted extensively about coding consistency and practices with Joseph Veroff, second author of the 1957 AVTMH study and first author of the 1976 AVTMH study. Our coding scheme was developed in conjunction with coding rules he and his colleagues had used previously. Thus, we feel confident that our approach to the data is in keeping with that of the original investigators. When new 1996 phrases and idioms were encountered, we sought to remain faithful to the original coding structures as we added them to the coding system. Thus, we hope to have minimized serious inconsistencies in interpretation of responses caused by differences between today's cultural context and the cultural context of 20 and 40 years ago.

Summary

Data from three public surveys over the past 40 years show changes in how the current generation is perceiving and responding to mental health problems. Still, it is unclear whether the number of nervous breakdowns has increased over the past 40 years, or whether the meaning of the term has changed so that the public's attitude toward psychological problems has become more accepting. We suspect the data in this study represent an attitude shift on the part of the public, although it is possible that the number of persons with diagnosable mental disorders also has been increasing. In either case, it is important to note the increased public acceptance of indigenous and nonmedical sources of help for these problems. Overall, the American public's preference for dealing with impending nervous breakdowns through informal supports and nonmedical mental health specialists appears to be at odds with trends in the practices of the mental health system. Physicians are now expected to play a more prominent role in mental health care, yet it seems that Americans are less likely to turn to their physicians with their mental health concerns. The American public's views and the health care industry's mental health care practices appear to be heading in opposite directions, when it should be a time for the further development and dissemination of effective psychological prevention and treatment programs.

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