MENTAL ILLNESS, THE MENTAL HEALTH

MOVEMENT AND THE TREND TOWARD

A THERAPEUTIC SOCIETY

by

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ABSTRACT

This study was designed to examine critically the various
theories, assumptions, and practices employed in the field of
mental health that define, identify and classify mental illness.
Necessarily, it looks at consequent practices and treatment
methods as well.

It does so because of the paucity of success experienced
throughout the field of mental health, the lack of consensus
and universality of opinion concerning definition and identi-
fication of mental illness, the lack of significant inroads
in the arrest and amelioration of mental disorders generally,
and certain conceptual ambiguity, contradiction and confusion
which prevails throughout the entire mental health movement.

The initial stage of this research involves a statement
concerning the present situation. The statement allows some
perspective to be developed and, more importantly perhaps,
raises certain questions the answers of which are central
to the critical nature of the thesis. It also allows insights
into the reported dimensions of the mental health movement
and the problem of mental disorders and, the allocation and
distribution of human and material resources.

The central part of this research confines itself to a
review and examination of celebrated theorists and theories

in the field along with the distinctive approaches of
current research in the field, both promise and
shortcomings.

The last stage of this research directs itself to the
development of an historical perspective in which human
thought and behaviour may be viewed and evaluated in relation
to the systems of values in existence at any given time
throughout history.

The concluding chapter contains a discussion of the
difficulties encountered in trying to resolve the many
contradictions, ambiguities of language, conceptual
confusion, and the ethno and ego-centric biases at work which
tend to hamper and constrain meaningful research in the
field of mental health.

To Kathleen, my companion and wife, whose
continued encouragement and emotional support
were vital for the completion of this paper;

To my Mother and Father for their never-failing
support and encouragement;

To Fred, Hal', and Tom for their patience,
continued support, constructive criticism,
and refreshing insights and perspectives;

To all my colleagues at school and work
who have, in their own inimitable ways,
made a contribution to this paper through
their ideas and practices;

And last, but by no means of least importance,
to those many children and parents my work
has brought me in contact with for it is
they who ultimately determine the extent
and depth of my education by offering real-
life challenges to the many theories and assumptions
I hold. The result of this has been to make
me sensitive to my own position and biases and,
to try and understand human behaviour without
condemnation.

MENTAL ILLNESS, THE MENTAL HEALTH

MOVEMENT AND THE TREND TOWARD A

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CHAPTER I

INTRODUCTION

If we are to believe current statistics, the phenomenon of mental disorder within western society generally and within Canada and the United States in particular continues to grow at unprecedented rates, that is, in absolute terms. This growth in incidence and prevalence occurs despite the commitment of large sums of money, material and human resources to the mental health field. Notwithstanding the size and scope of this commitment, the purported sophistication of treatment methods and facilities, the growing emphasis placed on educating the general public and, the popularity in western society of the psychological disciplines and the kind of introspection and preoccupation it fosters for "things of the mind", the success rate in the mental health field remains painfully low. It is suspected it is little or no better today than it was during the mid-nineteenth century when "moral-therapy" was the prevalent form of treatment.

There are thousands of books, and probably more research papers, written on the concept of mental illness. This abundance of literature reflects various perspectives and disciplines. It is fair to say that in the field of mental health, at least, collaboration between disciplines is now quite common. The diffusion of knowledge has tended

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to blur some of the distinctions separating disciplines. Despite this inter-disciplinary collaboration and despite the proliferation of scientific research in the mental health field, we are no closer today to understanding or reaching agreement on the phenomenon of mental disorder than were our "unscientific" predecessors. There is, as yet, little common agreement as to what constitutes a mental disorder. Nor is there anything approaching universal consensus on systems of identification, diagnosis, and classification. Despite our considerable efforts, notions of causation and etiology elude confirmation.

Notwithstanding any lack of consensus and productivity, research continues to grow on an unprecedented scale and the mental health field is expanding rapidly. Additional personnel are hired, new facilities are built and old ones expanded based upon practices and systems of knowledge that have not been rewarding - at least in the sense of original promises and theories. The field of mental health is unable to offer credible explanations for those behaviours which it seeks to treat nor substantive reasons for those practices carried out in the name of treatment. Their credibility relies heavily on the "good intentions" behind them, and little on anything resembling substantive evidence.

Throughout human history there have existed varieties of behaviours, of human conduct, which have been viewed as innappropriate and forbidden. The kind and quality of this forbidden behaviour has varied with the society as it has with the particular time in history in which it occured. The explanation for such behaviour has also varied according to the culture and to the normative, ethical and moral constraints therein.

The legacy of western civilization, in particular North-American society, is that it has at present a fairly refined system of classification whereby behaviours that deviate may be measured and codified through systematized forms of identification.[1] Human behaviour is constrained proscriptively through law by way of criminal and civil codes of conduct and, prescriptively through medicine. Implicit and explicit in both law and medicine are normative considerations.

Law and medicine possess mandates strikingly similar. Both address themselves to human conduct, to the identification and delineation of certain acts and behaviours as deviant. Both afford treatment and correction. Under law, people who violate certain prescribed rules and norms are labelled and treated as criminal;[2] in medicine they

are viewed as sick. In both areas treatment and correction is applied as a natural consequence.

The major difference separating law and medicine is that criminals are usually deemed and held responsible for what they have done and sick or ill people are not. Methods of treatment and correction are applied by law in an arbitrary, coercive, sometimes punitive fashion whereas in medicine, but not necessarily psychiatry, some degree of agreement and spontaneity is generally achieved. Both law and medicine are, however, becoming ever more sophisticated and elaborate in their respective proscriptions and prescriptions governing acceptable and normal human conduct and behaviour. (Whether this is "good" or "bad" is not of importance here. Our concern is limited to the increase in complexity in rules and norms constraining and affecting human conduct).

This paper develops a perspective in which present-day systems of identification and codes of human behaviour may be viewed in some sort of evolutionary/historical context. The relative nature of human behaviour is made apparent as is its transient, changing quality. The phenomena of mental illness in our time must be viewed not in isolation, as peculiar to our time and place only, but in relation to an entire history of idiosyncratic conduct. The significant

changes in human conduct and behaviour throughout history
have not been through any substantive change in nature, it
seems as much as it's been in the way we have chosen to
interpret, identify, treat, and respond to particular behav-
iours and conduct.

The accuracy and truth contained in an historical
perspective is substantiated in part if not wholly by cross-
cultural studies. Simply, what may be normal and acceptable
conduct in one culture may be abnormal and totally unaccept-
able in another notwithstanding that the intrinsic quality
and pattern of behaviour is identical in both cultures.

Intertwined with the historical/cross-cultural
perspective is the development of western thought and its
fetish with things-of-the-mind and introspection. This
preoccupation with things "psychological", re-inforced as
it is by various philosphical and religious themes, has
successfully maintained the schizophrenic dichotomy and
dualism of mind and body. It has served to direct mans'
attention away from his social existence and circumstances
for answers to his being, to his inner world or self. It
has tended to uphold the purity of thought and reason at
the expense of his sentient nature.

People today may or may not be subject to more stress, anxiety and emotional problems and difficulties than their predecessors. Certainly the reasons for stress have changed. However, the qualitative nature, that is, the physiology of stress and anxiety appears the same. This is not the issue here. What is of signal importance is the fact that people today are educated and thus predisposed and capable of identifying stress and anxiety in themselves and in others. The effect of the various media portraying people in conflict and with emotional problems has been to create easier recognition of these conditions and to foster and support a growing sensitivity to these kinds of behaviours.

Simply, Canada today may indeed be experiencing an unprecendented increase in both prevalence and incidence of mental disorders throughout the general population. What we are experiencing is an increase in public awareness, sensitivity, and sophistication in number and methods used to identify and detect mental disorders. Until the independence of these two factors is established, present figures, policies, and practices of the mental health movement remain suspect.

CHAPTER II

DIMENSIONS OF THE PROBLEM

Citing figures with ease and facility experts and exponents of the mental health movement demonstrate that mental disorders and the problems of mental health in Canada continue to grow at unprecedented rates. Notwithstanding the general paucity and unavailability of meaningful statistics for the period prior to 1955,[1] the data available are used as evidence of the incidence and prevalence of mental disorders within the Canadian population.

These figures are critical to the perpetuation and growth of the mental health movement and are cited to bolster and offer substance to the various arguments presented asking for increases in budgetary and fiscal allocations. Their examination is necessary, then, for some sense of proportion.

1. Probability of Admission to a Psychiatric Institution[2]

Of the estimated number of 19,644,00 persons living in Canada in 1965, 2,390,805 (1,256,925 males, 1,137,879 females) were expected to be admitted to a psychiatric institution on at least one occasion during their lives.

As a percentage this represents 12.7 of the male and 11.7 of the female populations.[3] These figures are conservative. They do not include persons with mental disorders being treated privately by psychiatrists, in out-patient facilities, in general and allied hospitals by family physicians and, perhaps the greatest number of all, those who do not obtain treatment of any kind whatsoever.[4]

The remaining 17,249,196 persons would not be expected to be admitted because (a) they will remain mentally healthy, (b) they do not utilize the reporting inpatient facilities even though in need of treatment or utilize other (outpatient, private psychiatrists, etc.) facilities, or (c) death will "rescue" them from admission to a psychiatric institution by intervening before they develop a mental disorder requiring admission.[5]

The probability of admission to a mental institution varies with age. At birth (age zero) for example, there were 222,400 males in Canada in 1965. Of this number 16.1 per cent, or 35,806 persons, could be expected to be admitted from this age group at some time during their lives. By way of comparison, at age 20, again in 1965, there were 151,000 males in Canada. Of these 15.6 percent, or 23, 634 persons, could be expected to be admitted at some time during the remaining years of their lives.[6] There are

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strong indications that there is now an increase in "probability of admission" for all age groups, consistent with the general over-all increase in admissions and increased sophistication of diagnostic methods. Whether or not this increase is confined to one or more age groups is not known at this time but would seem to be worthy of further study in light of the purported rising incidence of mental disorders in ever younger age groups.[7]

A factor of significance has been that since the mid-1960's, while the annual number of admissions[8] has continued to rise, there has been a corresponding decrease in the number of patients "on books",[9] that is, in the actual number of people in institutions at any given time.

2. Admissions

In 1969, admissions to mental hospitals in Canada, as one indicator of the prevalence of mental disorders within the Canadian population, numbered 97,195. This represented 6 per cent more than during 1968, 24 per cent more than in 1965, and 218 per cent more than in 1955.[10] In 1970, admissions were up 8 per cent over 1969, or, in real figures numbered 104,904 persons;[11] and in 1971 numbered 110,725 which represents an increase of 6 per cent over 1970.[12]

These figures representing admissions are misleading
unless consideration is given to the numbers of admissions
which are, in fact, readmissions.

3. Readmissions

True readmission rates, which would reflect the
success or failure of hospital treatment, are based on
the population at risk, i.e., on the population of former
patients.[13]   This population is unknown and figures
representing such population are either unavailable or
incomplete.

The data available representing readmissions is not
a count of patients, however, but of events, i.e., in
many instances patients leave the hospital but are kept
on the books as patients and on their return no admission
is reported.[14] Despite the absence of this particular
kind of information, the figures available indicate that
from 1951 to 1964 readmissions relative to total admissions
have been on the increase, i.e., from 1951-61 a 400 per
cent increase; 1954-64 a 300 per cent increase. (In 1961,
out of a total of 76,624 admissions[16] 18,039 were
readmissions.)[17]

Although the number of readmissions has risen steadily

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over the years this has not necessarily meant an increase in rate of patients "on books" or a proportionate increase in figures reflecting patient days. Because of decreasing average length of stay the trend has been in the opposite direction.[18] (We shall comment and enlarge on this later). What is of interest is that of the reported readmissions the majority (53 per cent) have experienced more than one previous admission.[19]

4. Factors Affecting Lengths of Stay

Figures on admissions indicate that while ever larger numbers of people are being admitted and are returning to mental institutions, they tend to stay shorter periods of time than previously experienced.[20] We may attribute the trend toward shorter periods of hospitalization mainly to the discovery and use of psychopharmaceutical agents, such as valium and chlorpromazine, and to the development of out-patient facilities such as boarding homes and regional and local clinics. The employment of antaractic-anxiolytic sedative-type drugs in the treatment and control of mental disorders is now widespread. These sedative-type drugs are primarily prescribed as agents of control.

That sedation remains a significant factor in the

treatment of mental disorders and constitutes one of the
principal methods may be seen through its increased use.
In 1964, sales of antaractic-anxiolytic sedative-type
drugs in Canada totalled 12.2 millions; in 1968 they
had climbed to 22.6 millions.[21] Although these sales
reflect consumption for the Canadian population as a
whole, it is reasonable to assume that a proportionate
share would be consumed by patients in mental institutions.
(In fact, patients in mental institutions probably account
for a disproportionate consumption due to the need for
heavier levels of sedation).

It seems evident that chemotherapy offers little other
than control when we view the increase in number of re-
admissions. Despite the falling number of patients-on-
books, at any given time, more people are being admitted
annually to mental institutions. Since 1968, at least,
the turnover rate, that is, the ratio of admissions to
patients-on-books at years end, has increased steadily.
In 1968 the ratio was 1.33[22]; in 1969 1.47; and, in 1970
it had reached 1.65[23]. The trend toward shorter lengths of
stay followed by an increase in readmission rates reflects
poorly on the lasting effects of current psychiatric
treatment.

5. Lengths of Stay

Since 1955, there has been a fairly steady decrease in
the proportion of long-term patients in mental hospitals and
an overall increase in number of patients-on-books for
shorter periods. As we noted earlier, at the end of 1955,
8 per cent of all patients had been under care for less
than four months and by the end of 1961 this figure had
increased to 11 per cent. In the same period the
percentage of patients on books for ten years or more
dropped from 42 in 1955 to 39 in 1961. This trend is
continuing. However, in this same period (1955-1961)
it is worth noting that 23 per cent of all patients had
been on books less than one year while 20 per cent had
been on books for twenty or more years.[24]

On new admissions to mental institutions as a
percentage of hospital population (in any given year)
we find little significant change over the years. In
1962, for example, of all patients-on-books over one-
fifth had been admitted that year, 56 per cent had been
enrolled over five years, 41 per cent over ten years, and
21 per cent over twenty years.[25]

Consistent with these figures has been the changing

distribution of lengths of stay. In 1955, the total number
of patients hospitalized two to ten years or more was
50,489 or 75 per cent of all patients on books. In 1964,
the number of patients in real figures had climbed to 53,184
but nevertheless constituted a drop to 69 per cent of all
patients on books for that year.[26] Again, while the number
of annual admissions go up, the lengths of stay go down.

6. Mental Disorders in Younger Age Groups

One indication of a rise in incidence of mental
disorders within Canadian society has been the increase in
rates of patients on-books for the younger age groups. For
age groups under 30 it was 183 per 100,000 population in
1955. In 1965 this figure had climbed to 208.[27] Mental
disorders in this age group fall mainly under the heading
of "defective", "psychoneurotic", "pathological personality",
and other character and behaviour disorders; that is,
disorders associated with childhood and young adulthood.[28]

The rise in incidence of mental disorders in young
people has been a source of concern to the entire mental
health field.[29] The Canadian Mental Health Association
(now known as Mental Health Canada), in a comparison of
studies they had conducted at various times, found that
whereas a few years ago it had been estimated that one

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out of every ten children would spend some part of their life in a mental hospital it was now estimated that one out of eight would become mentally-ill and require hospitalization. In fact, the estimates of the Canadian Mental Health Association(C.M.H.A.) appear to be conservative. The Commission on Emotional and Learning Disorders in Children (C.E.L.D.I.C.), upon the completion, in June 1970, of a three year study of Canadian children reported that "....one million of them, representing about twelve per cent, need care and treatment immediately because of emotional and learning difficulties."[30] According to these reports, the situation is fast becoming critical.

7. The Economics of the Mental Health Field

Economically, the mental health field is big business and present trends indicate that it will continue to grow and become larger. Recent American figures estimate that the cost to the American economy for the more than 200,000 hospitalized schizophrenics alone exceeds $14.0 billions annually.[31] This figure includes not only the direct costs of hospitalization but welfare subsidies to family members and the loss of earned income. A breakdown of cost is not available for the Canadian schizophrenic population. It is reasonable to assume, however, on the basis of population at risk, persons hospitalized and the percentage of those

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who are being schizophrenic[32] that comparable costs, on a proportionate basis, are experienced in Canada. Indeed, as Canada in 1961 had at least 26,618 hospitalized schizophrenics and as welfare subsidies and allowances are somewhat higher in Canada than in the United States, we may be experiencing, proportionately again, a greater cost than the Americans insofar as our respective national populations are concerned.[33]

What is known is that in 1970 the total operating costs for all public mental hospitals in Canada amounted to $396.1 millions.[34] This figure may be compared with the total operating costs of $130.3 millions in 1961; $139.8 millions in 1962[35]; and $241.2 millions in 1966.[36] But $396.1 millions in 1970 is, according to one expert in the field, a conservative estimate. George Kenwood, executuve director of the British Columbia Division of the C.M.H.A. stated that $2.0 millions are spent each day in Canada on mental health, of which $200,000.0 or one-tenth, is spent in B.C.[37] It seems reasonable to assume that if we were to add to Mr. Kenwood's figures which, I believe, include the costs of community mental health facilities, the costs of welfare subsidies and loss of productivity and earned income to the economy, the real cost of mental health in Canada would stagger the imagination.

8. The Changing Distribution of Mental Health Staff

Out of the total operating expenditures for mental hospitals in Canada, in any given year, salaries and wages make up the largest single expense item. More interesting, perhaps, has been the steady increase in percentage out of the total operating budget which salaries and wages have assumed. In 1962, for example, gross salaries and wages for all staff amounted to 66.4 percent of the total expenditures for public mental hospitals[38]; in 1966 they had climbed to 71.3 per cent[39]; and in 1970 they represented 76.8 per cent of the total operating budget. Simply, expenditures for personnel represent the most significant cost item, both in fixed terms and in proportionate annual increases.

More significantly, perhaps, has been the inconsistency experienced in the general overall increase in number of full-time staff. The reduction, proportionately, of the number of nursing personnel or line staff to professional and administrative staff, or those who have face-to-face relations and work intimately with patients on a day-to-day basis, has not kept pace with the increase in number of other personnel. Administrative and other professional groups have increased in number at the expense of line staff. This trend is continuing. In 1966, for

example, there had been a general overall increase in staff complement from the previous year of 4.1 per cent. Of this number nursing staff accounted for 56.1 per cent of the total, administrative staff 7.2 per cent, professional and technical staff 6.9 per cent, and medical staff 3.1 per cent.[40] In 1970, while real numbers of nursing personnel had increased, as a percentage of total personnel employed they had dropped to 53.3, while administrative and medical staff showed corresponding increases.[41] What seems to be indicated by these figures is that while the number of nurses employed in the mental health field is increasing generally, the ratio of nurses to other personnel and, more importantly, the ratio of nurses-to-patients, is deteriorating. While the number of nursing personnel has increased each year it has not increased sufficiently to alter in any appreciable way the nurse/patient ratio because of the annual increase in admissions.

The increase in number and changing distribution of mental health personnel has been occuring for some years now and is reflective of the oft-heard premise that in order to do a better job and obtain better results more workers are required with better training (education). Unfortunately, in the social service field generally and mental health field in particular, there is not a shred of evidence to support this notion. What usually occurs in

situations where "adequate" personnel with high qual-
ifications are provided - found in most experimental
projects - is that the so-called success rate remains
about the same as it always has. (We shall explore this
in more depth later). Generally, the higher the ratio of
mental health workers to general population, the higher the
detection rate of mental disorders within the population.
This does not mean, however, that an increase in incidence
and prevalence is being experienced but may simply acknow-
ledge the increase in number of personnel doing the
detection and reporting. It is not known at this time
whether a significant correlation exists between increases
in number of staff and the purported rise in incidence and
prevalence of mental disorders when the general increase
in population and population at risk are given consider-
ation. What is suspected is that as more services and
facilities are provided the more they tend to be used by
everyone, staff and patients alike. But whether this is
a factor of significance remains to be resolved elsewhere.

Sufficient to say that the exponents of the mental
health movement tend to employ the data which is available
to demonstrate that not only are mental disorders on the
increase within the Canadian population, in absolute
rather than relative numbers but, to substantiate their
case for ever bigger budgets.

9. Summary

First admissions to psychiatric institutions in Canada have nearly doubled in the past 10 years, 25,346 in 1960 to 46,408 in 1969. This increase is not relative to increases in population i.e., the rate of admissions per 100,000 population has gone up from 143 to 220 in the same period. Since the early 1950's the lengths of stay for patients in psychiatric institutions has dropped due, in part at least, to the discovery and introduction of psychopharmaceutics as agents of control and treatment. Consistent with shorter lengths of stay has been an increase in the number of readmissions. Shorter lengths of stay coupled with higher readmission rates has tended to create what is commonly referred to as the "revolving-door" syndrome.

But patients in psychiatric institutions reflect the tip only of the mental health ice-berg. According to the general director of the Canadian Mental Health Association (1971), Dr. J.D. Griffith, our statistics are beginning to look ominous.

> "There is substantial evidence to indicate
> that the lifetime prevalence of serious
> mental disorders is well in advance of
> the traditional one in 10..." [42]

Dr. Griffin suggests that it may now be as high as one in four.

What the statistics do not show is how many of the
more than one-million visits Canadians make to their
family doctors every week are for psychologically
related disorders? How many family doctors are treating
and prescribing for basically mental problems i.e.,
emotional distress and exhaustion, anxiety, depression
rather than for purely organic or physiological
dysfunctions---if the distinction can be so clearly
made? The fact that the widespread increase in use of
sedative-type drugs has not been confined to psychiatric
institutions suggests that family doctors are in fact
dealing with and prescribing for psychologically related
disorders far more than we may first suspect. It is
resonable to assume that there exists here a hidden
cost-factor both personally and to the economy, as
well. One can only speculate as to its size.

These implications can only make suspect the
conservative estimates of the already enormous
dimensions of the Canadian mental health problem.

CHAPTER III

ASSUMPTIONS AND REFLECTIONS ON
PRACTICE, THEORY, AND RESEARCH

There is little reason to doubt the validity of the figures and data depicting the size and scope of the mental health problem notwithstanding their incomplete nature and the many questions they may raise in our minds. What is in doubt are the systems of diagnosis, identification and classification by which people come to be labelled as being mentally-ill.

Given the fact that a system(s) of identification exists and is employed - notwithstanding the lack of consensus and weaknesses inherent in that system(s) - the credibility of that system(s) is fundamental to the legitimacy of the consequences which naturally follow as that system is employed and made use of.

The rising incidence and prevalence of mental disorders within the Canadian population occurs despite considerable expenditures of human and material resources. This investment is intended to alleviate if not reverse the trend. Unfortunately, despite

this substantial investment there has been no corres-
ponding improvement in the over-all mental health
picture. Indeed, the (one-time) director for community
resources for New York State, Doctor Elaine Cumming,
has stated:

> "... there is no evidence (which demonstrates)
> that the work of child guidance with patients
> or with their parents has made any signficant
> difference to the attack rate of neurosis or
> psychosis in any community."[1]

Doctor Cumming made this statement after a trial period
in which therapeutic teams went out in the community
and became actively involved with families who were
assessed as having emotional problems with various
members. In light of these findings she suggests
that "...therapists are inspired by convictions
based on faith rather than certainty."[2]

Similar support comes from another source in which
the general credibility and efficacy of psychotherapy,
psychoanalysis and behaviour modification programs
are found wanting. Citing the results of several tests
involving several well-known therapeutic approaches
used and applied in the mental health field, in this
case applied to delinquent children, emotionally
disturbed children, and to 8,000 assorted mental
health patients, Norma Lee Browning discovered,

given the fact of control groups who received no
treatment whatsoever, no significant differences were
found between those who received treatment and those who
did not. About the same proportion of people improved,
got worse, or stayed the same, regardless what was
done.[3]

What these two emminent women suggest through
their criticism is that there is no credible basis for
current policies and practices in the mental health
field. Other authors[4] offer support for this view by
suggesting that when viewed historically, there has
never existed any credible basis for the policies and
treatment afforded the mentally-ill throughout the ages;
that the policies and treatment afforded these people
has been and remains predicated largely upon fashionable
social policy, itself a reflection of values in vogue,
rather than on anything resembling substantive knowledge.
Fashionable social policy and the values contained
therein, suggests Professor Cumming, constitute the
prepossessions or faith of the mental health worker
and go a long way in explaining why the mental health
movement continues along its present course despite
serious shortcomings and limitations of research
findings. She states that when the mental health
worker

"... has not been able to discover etiologies
nor the characteristics or circumstance of
immune populations he has, in his zeal, made
up the necessary information and then gone
ahead as if it were the solemn truth. Like
Bleuler and Charcot before him, the professional
in the field has had moments of admitting that
what it specified as etiological might not in
fact be so. But again, like Blueler and Charcot,
it has reassured itself that in any event, its
methods and practices were good things in
themselves"[5]

Dr. Cumming's insights remain valid.

1. The Dimensions of Research in the Field

To the statement of Cumming and Browning we might

consider the state of research in the field of mental

health. Despite the plethora of research papers, books

and monographs written and published throughout the past

fifty years on the nature and causes of mental disorders,

there remains a distinct lack of anything resembling

real success or progress into their understanding.

Using schizophrenia as an example Scheff found that

"... from 1920 to 1934, 1,778 papers, monographs,
and books were published on organic studies (alone).
for the period from 1935 to 1945...3,200 studies
may be found on this subject. (And), for the
period 1940 to 1960.. some 500 papers were
published on etiology."[6]

Even when allowances are made for overlap and duplication,

Scheff maintains that there have been at least 5,000

papers reporting research on schizophrenia since 1920.[7]

This vast array of research, its myriad forms and
specificity, and the purported rising incidence and pre-
valence of mental disorders in the Canadian population, if
viewed in conjunction with the large and growing recidivist
rate of those treated, indicates and supports the content-
ion that little real progress has been made, thus far, in
the understanding, treatment and prevention of mental
disorders.

Research continues, however, unabated and not
apparently, discouraged or deterred by the lack of real
success. In fact it grows in size and scope. Unfort-
unately, the same general presuppositions continue to be
held and shared by the majority of people working in the
field. This virtually guarantees that the basic assump-
tions regarding mental disorders will remain largely
unquestioned thus ensuring the same sort of questions
being asked, the same regimen of attempts, theoretical
formulations and, almost inevitably, the same practices.
What happens is the same old answers are brought forward,
dusted off, and offered as new, as startling breakthroughs
into the understanding and arrest of mental disorders.[8]

2. Medical and Medical-Like Models of Mental Health

The field of mental health is no longer the sole responsibility of medicine. This does not mean that medicine has relinouished its predominate tenure or that it no longer has considerable, if not ultimate, jurisdiction and responsibility for the diagnosis, treatment, and custody of the mentally-ill.[9] It means that over the past 70 years generally, and past 15 years particularly, we have witnessed a gradual erosion of the medical model as an explanation for mental disorders. This does not imply that the medical model has lost ground. Rather, it has been joined by an assortment and variety of combinations of other disciplines i.e., psychology, anthropology, sociology.

Medicine has far from given up its tenure in the field of mental health. Its influence is felt in other disciplines. Where conflict has arisen between the medical specialist and another discipline in offering credible explanations, that is, explanations for behaviour which extends beyond human anatomy, medicine has usually managed to co-opt elements of other disciplines and retain its integrity by providing medical-like models. While the medical-like model enlarges the perspective

it does not seriously question the general efficacy of
the medical model itself.

In medicine, pathologies are corrected by repairing
or removing organs and tissue; metabolic or endocrinic
imbalances, whether excesses or deficiencies, are
remedied by prescription of specific chemical or hormonal
substances; organic disequilibrium and dysfunction is
sometimes viewed as jeopardizing the mental state of the
individual; and neural dysfunctioning is viewed as basic-
ally physiologically determined. This is not to deny
that a meaningful correlation exists between physical
health and mental state (health). Indeed, to view
these processes as separate, self-sufficient and
independent is misleading. To mistake process for cause
is equally erroneous and misleading.[10] To assume certain
incidences of metabolic and endocrinic imbalances found
throughout the population of the mentally ill is causal,
as much research does, assumes not only that the imbal-
ance is of etiological significance but raises the question
of whether the imbalance itself causes the behaviour or
is simply a derivative or by-product of the process.
It fails to provide the answer to whether or not the
same incidence of imbalance may be found throughout the
otherwise normal population.

It is a fact that all too often we end up treating the sympton (behaviour) as the etiological agent. For example, we view the schizophrenic's behaviour not as a process which has a course to run (R.D. Laing) much like a fever in response to a virus, but as the precipitating agent itself. This means, then, that in most instances the symptoms of behaviour receive the attention rather than the process which it characterizes.

Erosion of the medical model has not posed much of a threat to medicine simply because the so-called revolutionary perspectives of sociology and anthropology, as they have melded with psychiatry and psychology, have embraced complementary paradigms of human behaviour predicated upon the fundamental principles of the medical model. Although allowing somewhat different and broader perspectives, the potential which sociology and anthropology have to offer by way of fresh insights into the understanding of human behaviour has been largely curtailed by the acceptance of the main principles of the medical model.

Medical and medical-like models of mental illness are ones in which etiologies may be an environmental agent, e.g. a virus in medicine, or an experience of

social or cultural deprivation in the sociological and
anthropological explanations. In either case, the
precipitating agent (virus or social experience) is
viewed as initiating processes within the individual,
the consequence of which results in mental disorders of
one kind or another. This view of mental disorder stems
from a conceptual framework which defines pathology as
being primarily intrapsychic and as occuring in individ-
uals, that is, as an individual malady.

Medical and medical-like models of human behaviour
are generally patterned upon organic and social functioning
and upon notions of homeostasis and equilibrium. They
hold a view of man and his mental and physical well-being
as being in a position of delicate balance between excess
and deprivation. This vital balance, as Karl Menninger
calls it, is maintained by a variety of physical and social
homeostatic mechanisms operating in the body and throughout
the social environment. The same analogies used to explain
physical and organic well-being are employed to explain a
person's mental and social well-being. Indeed, the
assumption held and analogy applied between a healthy
body and attendent healthy mind is too common-place to
repeat here.

3. Research

The largest proportion of research into the causes
of mental disorders remains exclusively within the field
of medicine. A significant proportion of the work and an
area which is rapidly gaining official recognition as one
of the leaders and most promising in the field has been
in the area of organic equilibrium studies. Research in
this area is, perhaps the most potentially promising.
Its success, however, by way of discoveries and break-
throughs and, more importantly, by way of offering
remedies, has been limited.

Organic equilibrium theorists have not been deterred
by this apparent lack of success. Indeed, as we shall
discover, their faith is unshakable. This does not mean
that some measure of success has not been experienced -
of the variety which new, innovative programs of
treatment seem to offer. Unfortunately, once the
initial enthusiasm and newness wears off and routiniz-
ation is established, a corresponding decrease in effect
and results is usually experienced. This seems to
suggest that it is not the methods of treatment
themselves that are of significance but the effect
which new experiences, enthusiasm and high morale have

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upon everyone, staff and patients alike, that is of first
importance.

One of the most eminent spokesman for this group
of theorists and researchers is twice winner of the Nobel
prize, Linus Pauling.[11] It is his belief that:

> "... mental disease is for the most part <u>caused by</u>
> abnormal reaction rates, as determined by <u>genetic</u>
> concentrations of essential substances."[12]
> (emphasis added).

By way of qualification, Dr. Pauling suggests that these
surpluses or deficits of vitamins or other chemicals may
especially affect the brain and nervous system bringing
on a kind of cerebral scurvy or, as he succinctly phrases
it, cerebral pernicious anemia.[13]

Orthomolecular psychiatry, as this method of treatment
is called, is predicated upon the belief that biochemical
disorders are responsible either directly or indirectly
(by way of lowering a persons threshold to certain kinds
of stress) for mental disorders. It relies on the
manipulation of naturally occuring chemicals as a means
of restoring health.

Doctor Pauling, well-known for his outspoken support
for the use of massive doses of vitamin "C" as a cure

for the common cold suggests that "...the existence of an insane mind in a metabolically healthy brain is unlikely."[14] He predicts that a new medicine, emphasizing nutrition, will soon invade all the areas of the mental health field because of an apparent failure of psychoanalysis and other conventional therapeutic methods. One result of this failure, he suggests, has been to direct scientists back to the concepts of the biological origins of psychiatric disorders that were current ninety years ago,[15] that is, back to the disease and illness concepts and legacy that medicine has given to psychiatry.

In much the same vein, a research team from Texas have been probing the probable biological cause of schizophrenia. Doctors Gottlieb and Frohman, a psychiatrist and biochemist respectively, have "...discovered that an enzyme deficiency in the brains of schizophrenic patients appears to upset the brain's metabolism.[16]

> "because of this enzyme shortage, an excessive
> production of methylated idoledmines become
> possible and, therefore, is probably responsible
> for the symptoms of the disorder (schizophrenia)."[17]

More specifically, what these two scientists hope to do is to learn if by restoring the amount of enzyme deficiency in the schizophrenic brain, the delicate biochemical balance will reduce the disease or even cure it.

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Unfortunately, Gottlieb and Frohman estimate that another five years will be required to determine this.

A researcher from the University of California has offered the idea that his discovery of a substance - unnamed and undiscovered as yet - linked with schizophrenia, may lead to a treatment for the condition.[18] Doctor Arnold Mandell, of the University's San Diego Medical School, reports that the "substance" appears to trigger production of hallucinogenic compounds in the brain which cause the same kind of symptoms as amphetamine overdose and schizophrenia. He investigations

> "... have revealed neuro-chemical mechanisms that appear to explain amphetamine psychosis and which may be responsible for abnormal behaviour associated with schizophrenia."[19]

Members of this distinguished group of researchers are not concerned solely with such well-known behaviours as schizophrenia. Indeed, they seek to extend the mental health mandate to include all undesirable behaviour. One research team in the United Kingdom for example, found indications that homosexuality in men and women may be caused by hormonal imbalances.[20] In practising lesbians the researchers found that daily secretions of androgen were abnormally high and their production of estrogen abnormally low. Among practicing male homosexuals, the

opposite took place. The researchers believe that these preliminary findings have "profound social implications." They indicate that homosexuality is created in the womb, the result of physiological rather than psychological abnormality.

The director of the research team, Doctor J.A. Lorraine and his seventy member clinical endocrinology unit, tried to show that just as forms of mental illness may be due to physiological reasons, i.e., hormonal or chemical imbalance, so may analogous defects play a role in imprinting homosexuality.

Unfortunately, the research team found that whereas certain (unspecified) mental disorders respond to certain medicines, no corresponding improvement takes place when homosexuals have their respective estrogen/androgen levels restored by injections of testosterone (for males) and estrogen (for females).

Few would seriously question the premise of good nutrition being fundamental to and essential for, good health. In all of the examples just cited, however, the underlying assumption is that the so-called imbalance, whether it is a "surplus" or "deficit", somehow is

responsible, that is has etiological significance, for the behaviour in question. What this group of researchers fail to see is the logical extension of their assumption: that if particular behaviours are determined by various combinations and levels of hormones and natural chemicals, then all behaviour, regardless of its assessed propriety or impropriety, is subject to the same kind of determinism. Research in this area fails to provide satisfactory answers to whether body constitution or cultural factors are the predominating factors affecting and constraining human behaviour and thought. To this point in time, biochemical research has failed to provide a conclusive answer to the question critical to its success and credibility: is the reported imbalance a cause or result of the behaviour and the process it indicates?

By focusing on organic and chemical processes operating within the individual, this kind of research tends to lose sight of, if not ignore, the context in which the "organism" lives out its life, that is, the ethical, moral, and social environments into which it is born and lives out its life. To label homosexuality as abnormal, for example, is to make a value judgment rather than a "scientific judgment" simply because homosexuality has not been proven harmful, in itself, to the individual

and his physical well-being nor in fact to the society at large. (This is not to ignore the mental or psychological "damage" that can occur from being homosexual in a largely heterosexual culture which tends to forbid that kind of behaviour and tends to view it as "sick" and abnormal). What has to be distinguished here, I believe, is some sense of jurisdiction, and it would appear that moral judgments are not, properly speaking, the realm of medicine. This would seem to remove homosexuality out of the realm of medicine and into the area of human morals and ethics if we are to assess its <u>acceptance or rejection as a social act, for it is nothing more than this</u>. To seek to find its causes within the body system rather than social system is misleading, to say the least.

Similarities in naturally occuring body chemistry levels, whether they are measured as low, high, or average, as found throughout the population of any given society, much less the world, does not guarantee, by any stretch of the imagination, similarities in behaviour. Once again, this is not to deny that body chemistry remains a factor for consideration in the understanding of human behaviour. But so is everything else. By ignoring the inter-dependency and inter-play of all facets of man's existence and experiences, bio-chemical research offers a simplistic, uni-causal,

deterministic kind of reasoning and explanation for human behaviour that stifles deliberation and detracts rather than enhances our construction and understanding of the human mosaic.

4. Development of a New Perspective

Sociological and anthropological themes of the medical paradigm acknowledge, indeed emphasize, the extreme importance and influence of the social and cultural environments as primary predisposing factors affecting the extent and quality of the psychological make-up of individuals. They relegate to subordinate positions of importance ideas of biological determinism and various notions of patterns of behaviour intrinsic and peculiar to man generally. Workers in the mental health field with sociological and/or anthropological "imagination" tend to uphold the significance of various cultural and social contexts as primary agents responsible for moulding and shaping the individual's personality and behaviour by way of governing, to large degree, the kind and number of "actualizing" opportunities and alternatives available. Despite the importance of this perspective, and whatever revolutionary potential it seems to offer (to the mental health field), thus far it has tended to maintain the efficacy of the medical model of human behaviour by

focusing attention on the individual, and the subsequent modification and correction of his behaviour, without due regard to changing the environment at the same time. It ignores, or refuses to accept as tractable, the social milieu in which people are born, grow up, and live out their lives. Almost paradoxically, it upholds the importance of the social and cultural environments as constraining forces but at the same time rejects, or at the very least relegates to a subordinate position, the idea that change in behaviour may be brought about by change in environment. When all is said and done it upholds the traditional view that it is easier, less threatening, and less expensive to change and shape individuals rather than social institutions, much less societies.

What all medical and medical-like models of human understanding and explanation share in common is their concern for the individual; it is he who is deviant, pathological, criminal, delinquent, psychotic, and neurotic; that is, the morbidity lies within and arises out of intrinsic processes. Accordingly, correctional and therapeutic techniques are designed to restructure the individual's sense of self-worth, re-establish his self-identity, re-integrate his ego, and to generally

re-organize the personality so that the individual may successfully re-enter and take his place back in the society and milieu from which he orginally came, with some sense of purpose. The "fault", "weakness", or "imbalance" lies within the individual and is viewed as a personal deficit, as a personal idiosyncracy and liability.

By the same kind of reasoning, all that is required to get the person back on their feet, that is, "rehabilitated", is simply a rebuilding, a restructuring and "shoring up" of his personal identity and sense of self, and to restore some semblance of integrity. To accomplish these things the individual will be exposed to and imbued with new ways and methods of problem solving with new values and goals; or, if it is a case where erosion has occured, restoration and strengthening of the values and ways that existed previously. Little thought is given to the social conditions from which the person is drawn and to which he must ultimately (or usually) return; that they themselves may be pathological, deviant, and morbid, and may require change. It is assumed, however naively, that once a person has been restored to a state of comparative health and regained a degree of composure, he will be able to cope with - even change, perhaps - his social conditions.

That certain social conditions and environments can
have deleterious effects upon the inhabitants therein is
hardly a new view. One writer[21] puts it this way:

> "... we endlessly intellectualize the pathological
> components of ... life, but passively refuse to
> change our social values and actions which directly
> maintain pathology, prejudice, and deviant behaviour."[22]

The reasons for doing so are obvious.

> "... it is much easier to describe the wide
> varieties of human deviancy and pathology than
> to work for changes that will root out these
> crippling conditions."[23]

In a forthright manner, this critic points his finger
at the mental health professional stating that effective
alternate programs have been available for some time but
that these same professionals who effectively control these
establishments and the traditional practices have been
long on rhetoric and short on action. "The pathology," he
concludes," lies much more in those who run the social
system than in those people who are routinely destroyed by
its inhumane operation."[24] Once more, it is easier (and
safer) to change individuals rather than the market
morality of our society.[25]

What nearly all supporters of the medical and
medical-like models of human behaviour share in common
is the belief that mental illness really exists as a

discretely indentifiable phenomenon, howsoever they choose
to locate and identify it. While the methods employed to
identify the phenomenon vary according to the disciplinary
bias of the observer, there is little disagreement that the
phenomenon under study exists. Unfortunately, and despite
considerable effort on the part of many theorists in the
mental health field, there is as yet no diagnostic tool or
methodology with the characteristics of real precision and
universal credibility. This has led to ambiguity and
confusion amongst the experts in the identification and
classification of mental disorders.

In fact, we are little, if any, better off than our
predecessors. Just as they relied heavily upon circum-
stantial evidence, intuition, social values, and the
prevailing mythical beliefs and notions concerning
human nature in their treatment of deviancy so are our
modern-day mental health experts employing and relying
upon the same kinds of methods in identifying today's
deviants (the mentally ill and criminal). As in earlier
days where the accuser and investigators were protected
(legitimized) by virtue of their position in society, i.e.,
clergy and public administrators, todays experts cloak
their practice under the guise of "treatment" and offer
comforting rationalizations for what they do by way of

appealing to man's humanity to man. "Science", and the respectability it commands, offers the ultimate legitimization. It protects the esoteric practices of the mental health field[26] by shrouding it in a mystical cloak that only the initiated can remove. Unfortunately, we are no closer today to comprehending human behaviour, whatever the variety, much less effectively changing or modifying it, than were our most ancient ancestors or our most recent predecessors, Pinel, Charcot, Tulk, or Freud. We must ask why?

CHAPTER IV

UNIVERSALS AND HUMAN BEHAVIOUR

Attempts at establishing some idea of the universality
of human behaviour, that is, behaviours common to mankind,
by way of cross-cultural analysis of specific mental
disorders have not been revealing - at least in the way
they were originally thought they might be. The work of
eminent psychiatrists and anthropologists such as Marvin
Opler,[1] Anthony Wallace,[2] and Irving Hallowell,[3] and
their respective attempts to fit mental disorders, at
least those believed common to mankind, into some sort
of cultural and cross-cultural perspective and framework
of reference, has met with limited success in the sense
that it has tended to substantiate cultural relativity
(or, as it is known in sociology, historism[4]) and
repudiate notions of intrinsic patterns of behaviour
common to everyone. What was discovered by these investig-
ators was that behaviour which is viewed as abnormal or
labelled as schizophrenic in one culture may be perfectly
acceptable and appropriate, if not highly valued in the
case of seers and mystics, in another. They found the
rules concerning human conduct which purport to have
universal validity and credibility quickly break down when
applied to the uniqueness of individual action, especially
within the context of a particular society or culture.

Through their research and respective experiences these respected authors found that cross-cultural studies and attempts at establishing some sort of basic guidelines for investigation are simply too overburdened with ethno-centric and ego-centric biases to be of much use. These biases, they found, were profound but nonetheless subtle. Most ideas of human development, at least those supported by western scientists, surround the notion of a linear type of development, i.e., the comparison of societies and cultures as to their relative level of sophistication of techno-logical devices, complexity of social arrangements, and that human societies and cultures progress along the same lines. Thus the bushman of the Kalahari and the aborig-inal of the Australian outbacks have not advanced or reached the level of civilization of western man. They are viewed as primitive. Of more importance, perhaps, is the implication held and almost always applied that the degree of technological development and sophistication demonstrates degree of mental development. The correlation between the two is not only assumed to exist but to have etiological significance as well.

Only now is a beginning being made in the comparison of societies with different social systems and cultural herit-ages being viewed in the light of them having had histories of equal length; that is, equal but nonetheless different.

As I suggested earlier, the comparison of societies and
cultures in the same stage of human, but not technological,
development without reference to the peculiarities and
uniqueness of their respective evolution and history assumes
that all societies unavoidably pass or fail to pass, through
certain levels or stages of experience and competence.
Competence in meeting the needs of a society's members
is, of course, evaluated by a criterion held and applied
by "outsiders", in this case visiting anthropologists and
cultural/social psychiatrists.

According to Lindesmith and Strauss, these outside
investigators are, more often than not, uncertain of the
meanings of specific acts being performed by the "natives"
because of their inability to "escape" their own cultural
frame of reference. Neither is impartiality or objectivity
ensured when residents from the culture under study form
the investigating group, due to the effect education has
had upon them. That is, being educated means to come to
share and hold concepts, and thus a way of viewing and
interpreting the world, makedly different from that
previously held. So-called natives are no exception.
What this means is whatever meanings that are finally
developed by any investigators or observers, on whatever
level, are his own inferences.[5]

"the terms that are used...are inevitably taken
from western psychological vocabularies, and
inevitably lead...one to think of the people
under investigation according to western models
with which he is familiar."[6]

Lindesmith and Strauss go on to suggest that the effect

of this cultural bias is so substantial and yet so subtle,

that it requires years of immersion in the culture under

study before it can be said to be reduced to a level which

allows some degree of objectivity. Learning the language

and living in the culture is simply not enough. One must

begin to think, act, and behave - that is, respond - in

like manner before it can be stated that true meaning is

being extrapolated and understood.

The implications contained here for understanding

the mentally-ill are enormous, for who can claim to

comprehend their "some-times" incomprehensible "language"

and behaviour? Moreover, what is the criterion for

understanding? What does it involve? Is it possible

that we err in the same way cross-cultural studies have

done in applying interpretations of inordinate or unfam-

iliar behaviour into ordinary familiar conceptual schemes?

In this sense we may identify an ego-centric rather than a

ethno-centric bias at work. This would not only influence

our ability to understand the mentally-ill but would affect

and be a critical factor in the determination of what is
or is not mental-illness. The question raised here is
whether sub-cultural studies (and deviancy falls under this
category) display or have built-in to them the same sort
of bias as cross-cultural studies have been found to have?
We shall attempt to answer this question later.

CHAPTER V

PROMISE AND HOPE

1. The Promise

Concern and hope for discovering new insights into

causes, and thus paving the way for the arrest and amel-

ioration of mental disorders, continues to be focused and

our research guided along fairly narrow, structured lines.

Techniques of investigation may be categorized, roughly,

into three broad areas. These areas, and their respective

short-comings,[1] are consistent with contemporary inter-

disciplinary therapeutic team concepts and collaboration.

The first area focuses on identification and delin-

eation of deficits in the person; in effect, an examination

of what is wrong with the individual. Using this approach,

current research on schizophrenia, for example, found

that among the prominent symptoms were the inability to

use language logically or effectively; disturbed patterns

of learning and performance; decreased motivation or apathy;

distorted sensory acuity and perception, and disturbed

conceptual processes.[2] Complicating the generality of

these statements, the range of symptoms and elusiveness

of symptomatology is such that any research in this area

demands knowledge not only in the field of language

and communications but of emotions, motivation, perception, cognition, and personality, as well as the neural and endocrine bases of such behaviour.[3]

While the demand, obviously, is for inter-disciplinary collaboration and synthesization of significant data, the sheer complexity of data and the lack of any conceptual scheme satisfactory or common to all disciplines make it highly unlikely for research of this nature to succeed. Evidence of this breakdown in communication between disciplines is found through the results and fragmentary nature of current research. Despite the wealth of information published and brought forward in various areas, a psychiatric nosology of sufficient precision and specificity to be meaningful to all disciplines continues to escape us.

Such knowledge and data obtained through present research along these lines (behavioural studies) is, in itself, insufficient to answer questions concerning the second area of study, which directs itself to process and processes. Investigation into processes must rely, in contrast to behavioural studies, on the study of patients with disorders (apparent or real). A broad array of methods from the behavioural and biological sciences are being applied to the search for possible causative factors. Research in this area follows and seeks to determine the

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significance of alterations in body chemistry, genetic abnormalities and constituents, family relations and inter-personal communications, emotional stress resulting from traumatic events, and the various social structures and arrangements of communities.[4]

Finally, there is the search for effective treatment for those people already diagnosed as having mental disorders. Studies determining the mechanisms of psychoactive drugs, family interaction, the structure of personality, group dynamics, individual and group psycho-therapy, are constantly being undertaken in an attempt to better understand those social processes that may aggravate or ameliorate certain conditions. Again, results of any significance escape us; etiologies continue to elude confirmation and the field of mental health remains as much in the dark as it ever was. This is confirmed by more than one emminent spokesman in the field. The Surgeon General of the United States Department of Health and Welfare, in a Special Report on Schizophrenia, has declared that while we may "... cite figures with great facility... the process by which it develops, and the means for treatment elude adequate solution."[5] Thomas Scheff goes much further than the Surgeon General, however. He insists that, indeed,

"...there is no rigorous knowledge of cause,
or even the symptoms of functional mental
disorders. Such knowledge as there is,
is clinical and intuitive."[6]

The appalling lack of substantive knowledge has led

many researchers to re-examine their respective positions

and their conceptual frameworks. Amongst this diverse

group there is consensus that

"...not only in the field of schizophrenia, but
from all studies of functional mental disorders,
... not only have systematic studies failed to
provide answers to the problem of causation,
but there is considerable feeling that the
problem itself has not been formulated correctly."[7]
(emphasis added)

The most direct evidence of the paucity of success in

the research field is to be found through the results of

the various treatment methods. Using "hard data" as evidence,

Braginsky et al stated that statistics show clearly

"that even in the most up-to-date therapy centres
in the world, the numbers of persons who have
been successfully "rehabilitated" is painfully
small. The results are, in fact, no better than
those obtained decades ago... and... about the
same as no treatment whatsoever."[8]

That is, despite the increase, in absolute terms, of

numbers of trained workers in the field, despite the

proliferation of material resources and the number of

so-called innovative, therapeutic techniques, good

intentions and strenuous effort behind them, the

results experienced today in the mental health field are no better "... than those obtained decades ago by moral treatment."[9]

These results occur despite the "defensive" shift by psychiatry from one of blaming the hospital and the (purported) negative effects of institutionalization, to the (purported) positive, enlightened concept of community mental health centres. This shift of emphasis and accompanying transition from long-term hospitalization to decentralized community health centres has not, however, been accompanied by any substantive shift or change in diagnostic and classification techniques and criterion, or in the treatment of mental disorders.

Individual psychotherapy, group therapy, family therapy, occupational therapy, and chemotherapy, continue to be employed as treatment agents and mental disorders viewed in much the same way as they always have, as debilitating and dysfunctional. It has yet to be demonstrated that these methods of treatment and traditional systems of classification are effective and provide real opportunities for insights and understanding; that these methods are effective even in the most ideal situation with the most ideal of patients "... much less with the kinds of people... encountered in the mental hospital."[10]

It is not surprising then, that pressure for change continues to grow. It is less surprising that the nature of these pressures, reflecting the array of existing theories concerning human behaviour and development, lack agreement and consensus concerning the nature and quality of change that should occur. It is to this area we now turn.

2. Pressure for Change

Proponents and supporters of medical and medical-like models of human behaviour and human development and the conventional schemes of mental health and mental disorder, are under an ever-increasing amount of pressure and criticism, from various quarters, to search themselves and to change their ways. Ernest Becker,[11] writing of The Revolution in Psychiatry, challenges the basis for the medical paradigm. He advocates in its place a theory of a new understanding of man, based upon human development and scientific techniques, that is, a "science of man." Unfortunately, while insisting on more humane treatment of the mentally-ill, as people who have or need a sense of self-respect and dignity, who should not be denied their usual rights, Becker tends to perpetuate the stereotyped, conventional view that people who are mentally-ill are impaired, debilitated, and dysfunctional. He does suggest,

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however, to take the responsibility for the treatment
of the mentally-ill out of the exclusive control of the
psychiatric medical practitioner whose training has
emphasized, conceptually and systematically, the psycho-
somatic model of human behaviour. Why this must be done,
Becker argues, is that despite acknowledgement by psych-
iatry that neurosis represents "human confusion", mental
malfunctions are too surrounded and steeped in awe,
mystery, and the romance of medicine, that is, the legacy
of the "illness" and "disease" conceptual schemes, to allow
for any real progressive change in approach and treatment.[12]

In his call to rescind the medical model of human
behaviour, Becker seeks to re-orient research from its
present focus on individuals to social systems; away from
dynamic systems located within the individual to the
social and cultural settings within which the person
is resident and in which he lives out his life.

Becker's view is hardly new. But it is one which
continues to remain largely ignored - at least insofar as
any practical application or implementation of theory is
concerned. Indeed, both Marx and Freud, to use two
otherwise diverse theoretical viewpoints by way of example,
have alluded to the signal importance of the influence of
the social environment (milieu) as a "conditioner" of

man's mind: Marx, through his well known maxim concerning "the consciousness of man not determining his social existence, but, rather, his social existence determining his consciousness"; Freud, in his essay on <u>Civilization and its Discontents</u> in which he begins to acknowledge the predominance of the social structure and social institutions as factors of significance governing mans' mental forms by channelling and modifying his otherwise natural proclivities, that is, his primordial, instinctive, drives and needs.

More importantly, Marx and Freud were both aware, to different degrees, of the importance of the social and cultural implications not only in the determination, generally, of an individual's and society's "mental health," but of the difficulty involved in trying to change a state of mind (attitude) without changing the (host) social conditions: Marx, in his statement that "a demand that people rid themselves of their illusions is at once a demand to rid those conditions which require illusions"; and Freud's statement, "we shall probably discover that the poor are even less ready to part with their neurosis than the rich, because the hard life that awaits them when they recover has no attraction." Displaying a great deal of insight, Freud goes on to say that

"possibly, we may be able to achieve something if we
combine aid to the mind with material support."[13]

Nor are advocates of a new psychiatry simply the more
sociologically-minded, or people imbued with a "sociological
imagination" (Mills). Thomas Szasz and Karl Menninger,
both medically-trained psychiatric practitioners, support
the need for a revolution in psychiatry and in the field
of mental health. Szasz, in his book The Myth of Mental
Illness, attacks the traditional edifice upon which psych-
iatric practice rests and the general efficacy of that
practice. He suggests that the only things holding back
a "revolution" are the vested interests of conventional
practices and institutional pressures. He proposes, much
like Becker, "... to redifine the problem of mental illness
so that it may be encompassed under the general category
of (a) science of man."[14]

In a more recent attempt[15] at developing some sense of
perspective, by way of examining some of the presuppositions
upon which the field of mental health operates, Szasz dem-
onstrates a connection between "ethical convictions" and
"social arrangements," and an "immoral ideology of intol-
erance".[16] In doing so, he relies heavily upon establishing
an historical, evolutionary, "relativistic," perspective---

to be sure, simpler than that of Michel Foucault[17] and of George Rosen[18] - in which kinds of deviancy are tied to the existing morals and ethics (values) of any particular age.

Menninger, a neo-Freudian (of sorts), although more conservative than Szasz or Becker in his willingness to dump the medical model or to relinquish the kind of control it allows, demonstrates, at the same time, a marked impatience with the conventional systems of classification and their apparent limitations. He is concerned with the pejorative implications which these systems have in their application as they are used in the understanding, interpretation, and circumscription of mental disorders.[19]

> "we must view mental illness as personality dysfunction and living impairment... (we must) see all patients not as individuals afflicted with certain diseases but as human beings obliged to make awkward and expensive maneuvers to maintain themselves, individuals who have become somewhat isolated from their fellows, harrassed by faulty techniques of living, uncomfortable themselves, and often to others."[20]

These various awkward and expensive maneuvers, Menninger states,

> "are intended to make the best of a bad situation and at the same time forestall a worse one - in other words, to insure survival even at the cost of suffering and social disaster."[21]

Menninger's radical departure from conventional psych-
iatry may be seen best through his view that the mentally-
ill person is acting "normally," i.e., the best he can
and, perhaps, appropriately as well, for the situation
in which he is caught up. Unfortunately, Menninger's
early training has led to a conservatism[22] which
effectively forestalls his ability to offer or come up
with other than superficial alternatives and modifications
of the traditional theories and practices. His view that
the individual is simply "harrassed by faulty techniques
of living" implies that all that is required is to teach
the individual new or better techniques and his "mental
problems" will disappear. He ignores the correlation
between mental life and social being; he ignores the
social aspect as "treatable," malleable, and as amenable
to change. To his credit, however, he views mental
dysfunction and dyscontrol as processes and not as disease
entities positing, as it were, five levels of psychic
dysfunction (ego disintegration) on a dynamic, sliding
continuum.

It is in this sense that Menninger insists that
everyone, more or less and at various moments and times, is
a little neurotic, perhaps even psychotic, as they encounter
and resolve, more or less adequately and competently,

conflicts and problems they encounter. That they do not become neurotic or psychotic but for brief periods, perhaps fleeting moments, and thus escape detection and documentation, is more a tribute to the wealth and depth of their previous learning experiences and their social environment and position which have equipped them with the "tools" and opportunities for handling, managing, overcoming, and adapting to the new conditions and experiences, rather than to any intrinsic qualities which may serve to "ward off mental disease." It is also a tribute to, and a reflection of, the kinds of accomodations which are "built-in" to the culture and/or sub-cultural group, which allow, perhaps even sanction, idiosyncracies (differences) in behaviour.

In much the same way but carrying it further, Ronald Laing, perhaps because of his existential background experience, states that

> "... experience and behaviour that gets labelled
> schizophrenic is a special strategy that a person
> invents in order to live in an unliveable
> situation"[23]

Unlike Menninger, however, Laing insists that it is "the social system, not individuals extrapolated from it (that) must be the object of study."[24]

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More importantly, where Menninger found, but could not pursue to its logical conclusion, that some people, in some circumstances, and some of the time, after undergoing a schizophrenic experience, seem to get "better than well," that is, are better off for it by becoming stronger and more normal than anytime previous, Laing suggests that the experience itself may be a process of regeneration, a "normal" (natural) "adjustive" mechanism or process of mental functioning.

Menninger only goes so far as to state that mental dyscontrol may be a "natural"[25] process but fails to grasp the possibility that if it is natural it may be regenerative as well (notwithstanding his experience of seeing people get "better than well"). Menninger continues to view mental illness as dysfunctional and debilitating, as living impairment, as pathological.

What escapes Menninger are the deeper implications of his own discoveries, that is, the temporal nature and relativity of the normal. For example, if the schizophrenic experience is a natural, adaptive behaviour common to man generally but varies in meaning and interpretation according to the culture and context in which it is seen, it follows that it is to these systems of identification and definition

that attention must be directed rather than to the living expressions of those systems. If we are to understand and find out why people think and behave in the manner they do we had best direct our attention upon those systems of constraint at work on the individual rather than their results at work and evident within and through thought and behaviour processes.

Pursuing this argument in an attempt to develop some sense of perspective, Laing argues that in employing a term such as schizophrenia, he is not referring to any condition he

> "supposes to be mental rather than physical, or to an illness, like pneumonia, but to a label that some people pin on other people under certain social circumstances."26

And it is to these "social circumstances" that investigation must be directed. The cause of schizophrenia, he insists,

> "is to be found by the examination, not of the prospective diagnosis alone, but of the whole social context in which the psychiatric ceremonial is being conducted."27

The vital and integral part that the initial examination of the social circumstances play in the development of any sense of perspective may be seen, Laing maintains, in the clinical interview between psychiatrist and patient:

"a feature of the interplay between psychiatrist and
patient is that if the patient's part is taken out
of context, as it is done in the clinical description,
it might seem very odd. The psychiatrist's part
however, is taken as the very touchstone for our
common-sense view of normality. The psychiatrist,
as ipso-facto sane, shows that the patient is out
of contact with him. The fact that he is out of
contact with the patient shows that there is some-
thing wrong with the patient, but not with the
psychiatrist."[28]

If we can understand that any extension of the psych-
iatric interview, or "ceremonial," by way of psychotherapy,
requires, in part, that the patient must abandon his sub-
jective perspectives for those of the therapist's purported
objective ones, we may grasp the assumptions held by both
psychiatrist and patient alike that "the psychiatrist
knows what is going on and the patient does not."[29] How-
ever, by shifting one's focus from seeing the person out
of context to seeing him in context, "behaviour that might
seem quite unintelligible... can make quite ordinary
sense."[30]

That both psychiatrist and patient are constrained by
the nature of the circumstances and history which have
brought them together and the assumptions and presupposi-
tions implicitly and explicitly "built-in" to their
respective professional and social roles is, I believe,
self-evident.[31] That we choose to ignore, or down-play,
the extent to which these factors influence and constrain

both the nature (quality) and direction that the psychiatric interview (examination) or therapy session will take demonstrates our naivete - as opposed to innocence - and the extent of influence of our own prepossessions and biases.

(It is worth emphasizing here that psychiatrists rarely conduct interviews and examinations in the privacy of peoples', that is, their patient's homes. When they do, it is they who become out of context. My own experience in interviewing and counselling situations has led me to strive to see the person or family in their home, for it is clear that it is there that they feel most secure, at ease, less threatened and intimidated, and appear in context.)[32]

Another "revolutionary" in the field of mental health hoping to explode some of the myths is Erving Goffman. In his celebrated book on Asylums,[33] a treatise on "total institutions," Goffman reveals for examination some of the current myths and beliefs that surround and perpetuate various so-called therapeutic treatment facilities and programs found in mental hospitals. In so doing he attempts to point out the discrepancies between principle and practice, between official rhetoric and practice. He demonstrates that not only does the functioning of the mental hospital, as an administrative bureaucracy, tend

to stultify most therapeutic endeavours and ventures[34] but tends to interrupt rather than facilitate or offer support - if we are to accept Laing and Menninger's hypothesis - to an otherwise "natural" process.

The mental hospital and its operation are preconditioned by certain values and goals. Certainly it is a therapeutic institution; however, administrative efficiency is the superordinate goal and the striving for and achievment of this goal is at the expense of the people who are resident there. Although it is never explicitly stated as such - economic goals and considerations supposedly subordinate to the moralistic demands of a therapeutic milieu - the needs of the patients are secondary to the maintenance and efficiency of the hospital, as an economically viable organization, and to the administration of that operation generally. That these two needs (patient care and needs, and administrative efficiency) are not complementary but incompatible, if not antagonistic and antithetical, is well known but seldom mentioned or considered as a real factor in patient care.[35]

Braginsky (et al) has also helped to dispel some of the aura and mysticism surrounding psychiatric practice by way of empirically testing the efficacy of some of

the basic assumptions and "truisms" held and accepted

by mental health practitioners. He found that there has

been little, if any, noticeable change in the basic

paradigms and concepts of psychiatry over the years.[36]

Schizophrenics, for example, are still viewed as they

were 100 years ago,

> "... as something less than human; their illness
> is seen as a disintegrating disease process that,
> if not properly and promptly treated, may result
> in almost total psychic dysfunction. Moreover,
> it is still maintained that schizophrenics are the
> pawns of fate, unable to control their intrapsychic
> and external affairs"[37]

One-hundred years is a conservative estimate. Not

only are mental patients and mental disorders viewed now

as they were 100 years ago but treatment methods and

practices have changed little also. We continue to

exorcise, purge, and constrain the unacceptable illus-

ions, visions, and behaviours of patients by psychiatric

(rather than religious) trials and confrontration techniques

and by methods of schock, i.e. electric and, not too far

in the past, insulin and nitrous oxide, and by various forms

of control, the principal one today being chemical, and by

surgery (lobotomies through psycho-surgery).[38] As it was

and has been viewed throughout recorded history, certain

inappropriate behaviours and thoughts[39] have been "treated

and understood" in fairly consistent ways, depending on

the time and place. Although contemporary psychiatry

views the methods and practices of the ancients as crude

and unsophisticated, that is, the work of witch-doctors,

medicine-men, and physician-priests as simplistic and

magical, the fact remains that all that has been accompl-

ished to this point in time is a change in classification

and nomenclature. In contradiction to what Alexander and

Selesnick have stated to the effect that "man, the bene-

factor, having come a long way from the crude probings of

the pre-historic witch doctors and ancient physician-

priests,"[40] man, at least the patient, has not been the

benefactor of anything new; he is no better off now nor is

he treated much differently, than he has been throughout

history. As the mentally disordered were viewed then

they are now: as impaired, debilitated, as something less

than human.

We may agree with Alexander and Selesnick, however,

when they claim that "not only (has) psychiatry come of

age but... that our civilization may have entered an age

of psychiatry."[41] To be sure, the extent and influence of

the mental health field is immense indeed. It takes little

imagination to picture a natural consequence, a future

extension and elaboration of the already considerable

effort being expended in this direction, that is, the

arrival of the therapeutic community or society. In
the ideal milieu everyone, we may assume, would share
and support common goals, common thoughts, uphold common
values, and share common experiences. Necessarily, every-
one would come to know what constitutes inappropriate,
forbidden, behaviours and thought. In the therapeutic
society these are viewed as "unhealthy" and the person
who thinks and behaves thus is viewed as "sick," and as
in need of "treatment." The success of the therapeutic
society is directly dependent upon the level of success
of those methods and institutions by which social norms
are inculcated and internalized in a society's members.
Indeed, we have only to reflect a moment upon some of
our own more personal, intimate thoughts and imaginative
moments and the feelings of guilt that we occasionally
experience, to more readily appreciate the subtleness
but considerable extent to which we are already part and
supporters of, the therapeutic community. The complete
tranformation and transition to the therapeutic
community would be subtle but nonetheless effective.

3. Resistance to Change

It is argued by Braginsky et al that the relatively
unchanged conceptual scheme of mental illness over the

years is responsible for the lack of any real success despite the multitude of seemingly innovative therapeutic techniques and the ever-increasing sophistication of personnel employed in the mental health field.[42] Resistance to imaginative innovation, new perspectives and conceptual schemes, is rooted in the recognition that new ideas and proposals represent a challenge to a way of life. In most instances to a way of professional life in which one usually is firmly committed - limitations of conventional practice and paradigms notwithstanding. And it is in this way that new paradigms and conceptual schemes pose as threats to a way of (professional) life which has been thoroughly integrated into one's sense of self.[43] Needless to say, we do not change our sense of self as readily as we change our clothes, especially if that image is reinforced by certain rewards, i.e., self-satisfaction, prestige, power, influence, and monetary remuneration, which ensures a certain status and life-style can be achieved and successfully maintained.

That these are well-known but seldom publicized facts may be found through investigation into the fact that workers in the mental health field share common goals - themselves a result of common educational experiences and backgrounds - similar social positions,

and values. They come to share, then, an interest and direct investment in time, money, and styles and standards of living, and come to perpetuate by virtue of these "investments" those kinds of policies and practices which support, reinforce, and sustain their professional and social life-style. That these "self-interest" items are rarely held up for examination but are, in fact, primary considerations, is more a result and a tribute to the servicibility of, what I choose to call (with all due respect to the most distinguished of ladies) the Florence Nightingale Ethic, that is, the altruistic notion that helping others and self-sacrifice come before consideration for one's own sense of well-being. This sense of personal involvement, commitment, and self-sacrifice is, perhaps, the most predominant factor which characterizes the mental health field in particular and "helping" professions generally. More importantly, service and practice predicated upon these notions can hardly be challenged on their apparent motives. To suggest that these notions of altruism may be rhetorical conveniences which serve to cloak and disguise otherwise pragmatic practices which one segment of the population perpetrates upon another is to incur the wrath of not only those who work in the field but, as an example of the general acceptance and pervasiveness of this ethic, of the population at large. To suggest that people working in the mental health field

look out for themselves first gains little support because
it contradicts flatly the notions we tend to entertain
and behaviour we expect from people employed in the field.
Indeed, the Florence Nightingale ethic continues to live
and exert a powerful influence on the kind of ideology
that is offered and inculcated in persons entering the
field by way of the training and education they receive.
(In a more speculative vein, it would be an interesting
study to determine who and what kind ("type") of person
is attracted to and enters the social service field).

That ideology differs markedly from practice and
goals is supported, in part, by no less a person than
the director of the Behavioural Disorders Program at
the University of Wisconsin, Dr. Thomas Linton.[44] In
a critical book review article Dr. Linton takes exception
to the suggestion that adults who constitute the economic
basis of the social system and who manage the agencies
of control are unsure about how to exercise their own
perogative.[45] "This is utter nonsense", Linton states,

"the adults who control the various establishments
(and, mental institutions are "establishments") are
not at all unsure about their reasons for doing so.
They very consciously exploit every opportunity to
maximize their social and economic power - even if
these actions run counter to the general social
welfare and mental health of the society"[46]

How we disguise this pragmatic, utilitarian practice governing institutions is to cloak it under the respectable official mantle of humanitarian principle. And who can argue against altruistic motives? Although discrepancies and contradictions may exist between principle and practice they are seldom examined much less resolved. To do so would inevitably lead to the conclusion that in fact we know very little about human behaviour, and what we do know is largely a result of subjective, intuitive knowledge. Needless to say, it is therefore, not readily subject to verification by the methods of the natural sciences, at least as those methods have been modified and adapted to the social and behavioural sciences.

The suggestion is, then, that psychiatry, in the conventional sense at least, is re-inforced in it's use of medical-like conceptual schemes of mental illness (and in its subsequent practices) as being primarily intra-psychic, by virtue of its apparent safety; that is, by the fact that the therapist may remain apart from that he is seeking to understand and treat. But standing apart or remaining aloof from the individual's difficulty is not, however, a practice endorsed or shared by all emminent spokesmen in the field of human behaviour and social processes. We are reminded of the comments made

by Harry Stack Sullivan with respect to the necessity of
being a "participant observer", and those of the late
Karl Mannheim and his verdict that attempts to remain
apart from the social process and context being studied
does not constitute objectivity but a denial of the
essential nature of that process and the understanding
thereof. Needless to say, everyone exists in a social
context and process.

What is accomplished through maintaining a distance,
which the usual sense of objectivity requires, is that
the mental health professional effectively maintains a
relative position of superiority over his patients. In
so doing, he maintains the effectiveness of an accomp-
anying "crystallized heirarchy" of positions of offices
and statuses. This distance, it may be assumed, serves
to protect and guarantee his own status and integrity by
effectively subordinating the status and integrity of the
patient. In a word, the social and professional distance
separating therapist and patient tends to re-inforce,
positively, the status and integrity of the therapist,
and re-inforce, negatively, the status and integrity
of the patient. Whatever status and integrity the
patient may have had previously, the psychiatric cere-
monial is the instrument by which it is recast, in a

negative, adventitious way. The patient is offered
status and integrity only if he accepts the conditions
of his new role, that of being mentally-ill.

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CHAPTER VI

MENTAL PATIENTS AS PEOPLE

For people like R.D. Laing, Erving Goffman, Braginsky and others, symptoms of mental disorders are simply behaviours designed to control outcomes in social situations. This perspective is predicated upon the assumption that all behaviour is, at the same time and whatever else it may be and accomplish, a form of social communication. As such, these authors maintain, symptoms of mental disorders represent no special category of behaviour that needs to be distinguished from other behaviour. More importantly, they offer evidence that the utilization of symptoms need not be outside of awareness, but may reflect the deliberate, conscious, rational efforts of a person (mental patient) to attain his or her established goal, especially with respect to the constraints and rationale of institutions and institutionalized practices.[1]

Through the evidence of their respective research endeavours these authors found that, contrary to popular belief, mental patients have goals and, more importantly, most were quite capable of achieving them without the awareness and despite the efforts of staff. The major differences, they found, was that the goals of the

patients and goals of staff and of the institution with
respect to the patients, were diametrically opposed to each
other. The suggestion is, then, that hospitalization and
non-hospitalization occurs less for reasons of severity of
behaviour deviation than for the patient's own motives.
Consistent with this line of reasoning, Braginsky et al
argue that:

> "mental patients, for all their pathology, are in
> most respects, most of the time, just like the rest
> of us; they want to live in a mental hospital in the
> same way that ordinary persons want to live in their
> own community - that is, they can be expected to try
> to satisfy their needs and, to a considerable extent,
> to be able to do so"[2]

The evidence produced by this group of authors
indicates that, contrary to widespread opinion, most patients
were found to be directing agents capable of controlling
and acting out their life situations, in a more or less
purposeful way, for more than we allow or are willing
to give credit for.

The primary distinction to be made here is that the
goals of the mental patient are not those of the mental
health professional. Indeed, they may be completely
contradictory if not mutually excluding. Where the
professed goal of the mental health professional is to
re-integrate the patient back into the society as an

"economically" and "socially viable", that is productive person, the goal of the patient may be to remain in the supportive, sheltered, warm atmosphere of the hospital community. It would be naive to think that the patient, in these circumstances, does not know what behaviours will and will not tend to guarantee his remaining in the hospital. By the same token, those behaviours and the underlying rationale of wanting to stay in the hospital, if it should become known or suspected, is used as evidence of the persons unreadiness for release. In short, to want to leave the hospital and to resume one's place in society is interpreted as a sign of "health"; to want to stay in a mental hospital is interpreted as a sign of illness or pathology.

Preoccupation with "correction" of the individual and the tendency to ignore the social context from which he came, as many mental health workers do, tends to overlook if not ignore the fact that the social circumstances from which the patient is drawn may be more of a debilitating experience than that of the mental hospital despite the stigma of being labelled a mental patient. The same oversights may be seen in the field of corrections where the annual fluctuation of "counts", that is, numbers of prisoners or inmates, coincides with the weather and

season of the year. Gaols, at least prisons in British Columbia, tend to fill up in the late fall through winter and spring, and tend to empty in the summer months. This does not suggest that weather or season is the only or even the primary consideration. It is only one of many, i.e., socio-economic conditions and considerations of employment. The point being made here is that institutions, whether they are mental hospitals or gaols, provide a relatively "comfortable" alternative to some of the more deprived environments from which the majority of people in institutions are drawn.

To argue that no self-respecting person would humiliate or degrade themselves by purposely being admitted to a mental institution or prison is to apply a middle-class ethic and sense of reprehension to a lower-class situation. It ignores the fact that people drawn from those kinds of conditions and social situations have already lived a degrading experience; things can only get better; they have to improve. An appeal to middle-class notions of self-respect and integrity, as so much of our current appeal in the mental health and correctional fields is based, is almost useless if not wasted. The basis of the kind of appeal is predicated upon similarities of previous experience which tends to guarantee similarities in goals.

This disparity is probably one of the most significant factors preventing and standing in the way of establishing meaningful communication, and thus understanding, between those people labelled and held to be mentally ill and/or criminal, and professionals employed in the field.

Unfortunately, the prepossessions underlying and supporting conventional paradigms of mental disorder do not allow for other than the kinds of interpretations and practices which guarantee that people will stay in mental hospitals; that they should be there, especially if they proclaim that is their wish. Indeed, these basic assumptions are so thoroughly ingrained into a way of professional life that any data from psycho-social tests which seems to contradict and make suspect their credibility is either discarded, ignored, or the data is modified to fit the preconception. This may be of no surprise to people familiar with "self-fulfilling prophecies." In a study of role-taking, for example, it was predicted that schizophrenics would show poorer role-taking ability than "normals". To the researcher's surprise, however, differences favoured the schizophrenic population. That is, the schizophrenics proved more adaptive, flexible, and assimilative. This unexpected superiority could not be

explained - at least in terms that were compatible with this particular researcher's bias. As a result, the schizophrenic subjects superior sensitivity was correlated with that of disturbed children and passed off as hyperacuity. In this way both the paradigm and prepossessions of the researcher remained intact.[3]

In another test of this kind, Grayson and Olinger[4] found, much to their embarassment, that schizophrenics could "simulate" normalcy on the M.M.P.I. They managed to salvage their paradigm, however, with the statement that

> "some of these patients may have gained temporary control of their erratic and frequently unmanageable impulses without any new basic understanding or mastery of their impulses."[5]

These kinds of interpretation of test data are entirely consistent with one of the basic assumptions held by mental health workers about the mentally-ill: that when a person is mentally-ill they are, unlike organic and physical illnesses, totally incapacitated. That is to say, they are not peculiar in some ways but, necessarily and in contradiction to the purely medical model of human behaviour and functioning, in all ways. And in this regard we may better understand what inevitably happens to test

data that appears to contradict the preconceptions of
the researcher, that is,

> "... any apparent normal behaviour must be
> recast so that is indeed merely apparent
> and adventitious."[6]

Why a person who commits various errors in judgment
and exhibits unorthodox behaviours, (that is, a person
deemed mentally ill) is viewed as being untrustworthy in
all matters escapes logic. Perhaps it is a carry-over
and extension of the view, held by many, that the brain
constitutes the locus of that elusive phenomena, the
human mind, and the breakdowns in neural or physiological
functioning necessarily indicates a corresponding break-
down in mental functioning. Whatever the reason, to view
a single peculiarity in thought process and/or behaviour
as indicative of an over-all peculiarity contradicts
analogies that are usually made and employed from the
medical model where organic dysfunction, of one kind or
another, does not necessarily or inevitably mean total
incapacitation.

The bias of the mental health investigator is a fac-
tor of importance both in the manner in which the phenomena
in question is interpreted and in the actual design and
structure of tests used to identify and measure such phen-
omena. The difficulty and yet importance of escaping this

bias, whether it be of an ethno or ego-centric nature, is
well documented and succinctly stated by F.C. Wallace.
He states that

> "it is one of the conspicuous features of modern
> science that major advances in substantive knowledge
> depend upon major advances in self-awareness of the
> scientist. Only as the scientist comes to recognize
> and to take account of the limitations imposed on
> his vision by the concepts <u>he chooses to consider</u>
> <u>important, and by the assumptions he makes about</u>
> <u>the logic of inference and the technique</u> of observ-
> ation, can he achieve the flexibility of approach
> required to solve new problems"[7] (emphasis added)

Needless to say, the nature and extent of the training
of most mental health practitioners emphasizes medical-bio-
genetics and intra-psychic mechanism, thus effectively
constraining the attitudes, approach and, more importantly,
the possibilities for entertaining new conceptual schemes.
Until new ways are developed of viewing and interpreting
behaviours and thoughts that are different and unorthodox
the mental health movement will remain in much the same
state and position it is now and has been for years -
moribund!

CHAPTER VII

MENTAL ILLNESS :
AN EXERCISE IN CONCEPTUAL CONFUSION

To this point we have avoided discussing the concept
of mental illness and mental disorders generally, and
their credibility as concepts with meaning and precision.
We may conclude that insofar as the general idea of
mental illness is concerned most people would agree
that certain behaviours and peculiarities of thought
may be readily classified or categorized as abnormal.
Perhaps the best example of finding common agreement and
consensus is when a person, selecting and describing
particular behaviour or happenings, employs adjectives
such as "kooky", "weird", "odd-ball", "far-out" (etc.).
There is usually immediate understanding, if not agree-
ment, but in the most general of senses, that the
behaviour or thought being described was not ordinary.
It not being ordinary or common-place is also a condition
of how elaborate the explanation and context portrayed
was. Difficulty is reached, however, when we try to
become more specific. That is, consensus may not be so
readily achieved when particular behaviours and thoughts
are fitted into some context and explained with some sense

of perspective, with some sense of human motivation.
Simply, there may arise, in conjunction with the extent
to which an explanation is given, an understanding and
rationalization of what prompted the behaviour and of the
goals to be achieved. In this sense, less agreement may
be expected the more people possess information and thus,
potentially at least, can relate this information to
some of the experiences they themselves have had.

The mental health field has, as one of its anomolies
and serious weaknesses, identification and classification
systems that not only lack precision and specificity,
but vary both in their use and employment from practit-
ioner to practitioner, indeed, from society to society
throughout those countries which employ western mental
health systems and methods. What this suggests, keeping
in mind the remarks of Hollingshead and Redlich concerning
disparities in diagnosis between middle/upper and lower
socio-economic groups, is that the kind of illness
diagnosed is more dependent upon the social position,
training, and cultural bias of the observer than upon
any common intrinisic qualities of the behaviour so
identified and labelled.

And yet, despite this ambiguity and imprecision, unreliability and absence of common agreement as to what is or is not a mental disorder - in everything but the abstract - the system of identifying and labelling people as mentally-ill, as mentally incompetent, continues to be employed to a degree to which ever-increasing numbers of people are hospitalized and recommended for treatment every year.

What is being suggested here is that both the concept and label of mental illness is, for the most part, non-descriptive and pejorative. It tends to obscure rather than clarify the phenomena it seeks to identify. We shall now turn to some of the reasons for this.

We may recall that the main orientation and predilection of medical-psychiatry is toward a biological model of human behaviour and functioning. In maintaining this view it receives its primary support from such phenomena as syphillis of the brain, delerious conditions sometimes referred to as "intoxications," brain tumors, paresis, and menningitis; that is, illnesses in which persons are known to manifest peculiarities or disorders of thinking and behaviour. Correctly speaking, however,

these are diseases of the brain, of the nervous or
circulatory system, and of specific organic functioning,
not of the mind. The correlation between brain and mind,
or thought process, is not only assumed to exist, to be
self-evident, but is treated as a recognizable fact.[1]

Further, once the correlation is established it is
given etiological significance. When medicine speaks of
physical disturbances, it means signs, i.e., fevers, or
symptoms, i.e., pain. When it speaks of mental signs or
symptoms, however, it refers to a patient's communications
about himself, others, and the world about him.

More importantly, perhaps, is that these symptoms
of mental disorder are only discernable when manifest
through behaviour - that is, specific acts and conduct.
This means that what is being determined, in the evaluation
of that behaviour, is whether or not it is capable of
achieving the goals to which it is directed and, whether
the thoughts and reasons sponsoring the behaviour are
consistent with those goals. This means, of course, that
some evaluation is being made of the goal itself. For
example, if a man steals in order to obtain property,
while we may not agree with the means or method, that is
the act of stealing, the goal of obtaining property is,
at least within our cultural context, permissable, indeed,

highly fevoured. If, however, the man steals not for the
acquisition of property but for the pleasure which the
act of stealing affords, then it no longer becomes under-
standable or explainable - at least within our usual
framework of reference. Our reference points, are, then,
closely tied to our value systems and comprise a major
part of our interpretive schemes as well.

The correlation between thought process and behaviour
is not only assumed to be of significance, thoughts
sponsoring behaviour it is thought, but, by a subtle
process of transubstantiation, deviant behaviour becomes
synomymous with disordered and deviant thoughts and thought
processes. The kind of process is, however, hardly ever
articulated. Nevertheless, this system of assumptions
and practice of correlation is employed in most treatment
agencies. Its acceptance is so common-place it forms
one of the accepted "truisms" of Canadian and American
folklore. It is perpetuated in many ways. Ann Landers,
who we may safely assume is one of the most widely read
syndicated columnists, stated recently (Dec.22, 1972), by
way of reply to a reader, that people steal for many
reasons, the cause of which can usually be found in and
through the number and extent of disturbing, traumatic
experiences they may have undergone earlier in life.

By implication then, Miss Landers confirms that not only
is the act of stealing deviant but it could only be
perpetrated by a disordered or abnormal mind. While
theorists may deprecate and belittle the correlation and
significance of the assumptions Miss Landers suggests as
being highly misleading if not patently false, the fact
remains that Miss Lander's statement and underlying
assumption is probably closer to the mainstream of North
American thought than that of the theorists. Unfortunately.
Simply, if this kind of reasoning obtains for many it must
also include in its number a representative sample of those
people who commit the acts and those who enact, enforce,
and perpetuate laws, customs, and social policies. The
implications here are obvious. A degree of spontaneity
in agreement will be achieved by all parties concerned,
both transgressors and legislators alike, as to why the
act was done.

Insofar as the goals of stealing are concerned, that
is, the acquisition of property, they are credible. It
is only the means, that is, the act of stealing itself,
that eludes social endorsement.

Confusion in the concept of mental illness has been
caused, in large part, by the ambiguous nature of the

phenomena (behaviour) and by the kinds of descriptive

concepts employed, by semantical and conceptual confusion.

In a paper titled: Mental Illness or Interpersonal

Behaviour ? Adams states that

> "efforts toward understanding and effective allev-
> iation have been long hampered by semantic confusion
> which results when the word "illness" is used to
> denote both physical disease entities and maladaptive
> patterns of interpersonal behaviour. This ambiguous
> usage, has perpetuated the glib fallacy that mental
> and physical illnesses are the same thing."[2]

Citing evidence drawn from the development of

psychology as an independent science during the 1870's and

1880's, and its founders preoccupation with acquiring

scientific respectability by borrowing methods and concepts

from the physical and biological aciences, Adams argues

that the present use and employment of psychological

concepts simply reflects those borrowed earlier "from

non-psychological fields such as medicine, physics,

mechanical engineering, biology, and electronics."[3]

While the list of "pseudo" analogies listed by Adams

between the physical and biological sciences and psychology

provide interesting information, the conclusions he reaches

as to how these analogies mislead is of more importance

here :

"such analogies implicitly suggest that human
behaviour is just like the events observed in
the non-psychological sciences from which they
borrowed. In using such terminology a false
assumption is unwittingly made (but rarely stated)
that the psychological phenomena to which these
terms are applied are therefore just like the
non-psychological phenomena where the terms
originated. The actions of living persons are
thus conceptualized in the language of impersonal
things and processes."[4]

Adams suggests that the "supposed complexity of

personality and interaction between persons ...(is) a

purely semantic, verbal complexity, rather than a

complexity in actual fact."[5]

What Adams is suggesting is that the use of metaphors

and analogies from the natural sciences has obfuscated

an already little understood phenomena, that is, mental

illness. He also suggests that no real progress and

inroads will be made into the understanding and

amelioration of mental disorders until the metaphors

and concepts employed are "carefully and critically

re-assessed."

But Adams' views are hardly new. Indeed, Gordon

Allport, one of the better known psychologists, stated

back in 1947 that

"the medicine model in psychology had its origin
not in clinical or social experience, but rather
in adulation of the technological success of the
physical sciences"[6]

Allport, like Adams after him, blames the use and
employment of "root-metaphors" as having led psychology,
and whatever potential it may have had, away from rather
than toward, the problem at hand, that is, the under-
standing, arrest, and amelioration of mental disorders.
Unlike Adams, however, Allport makes the plea that as
psychology originated and was known as the "moral science,"
something could be gained by returning to that idea and
by rejection of the mechanistic models of human
functioning. In short, he suggests a return to moral
models of human behaviour. In making this plea, Allport
obviously had in mind the fact that so-called success
rates in the days of moral therapy in the mid-nineteenth
century, were actually somewhat better than those
experienced today. The practice was also more humane.

What escapes Allport is the already enormous influence
exerted by moral (normative) considerations in the models
of human behaviour at hand today, and which must necess-
arily obtain in whatever models are fabricated and
employed and in whatever evaluation is placed on human

behaviour and functioning.

1. The Importance of Values

Generally, and with respect to a concept of mental health, the field of mental health may be viewed as a system or means for establishing and perpetuating certain norms and values at the expense of others. It is, in this sense, less a science of mental illness than it is a movement for the prevention of "moral deliquency."[7] It has failed to offer satisfactory answers and thus legitimation for its major assumptions and for its practices. The field of mental health has neglected, ignored, and refused to see that when a substantial number of people cannot adhere or cope with the normative expectations of the community, it is important to look at the group responsible for creation of the legislation and determine just whose and what standards are being enforced and upheld and what means are being employed in their enforcement. The psychiatric professional, as one of society's most effective enforcement agents, has been too ready to impose middle-class standards on an entire society without regard for the acceptability of such standards by large groups who neither by educational or socio-economic background or experience are able to achieve, maintain, or

adequately understand those standards, much less cope
with them.[8]

The mental health professional, by refusing to
acknowledge the social system as being a primary agent
responsible for the systems of human injustice and
deprivation, and by avoiding the political implications
such recognition would bring has, by default, become an
agent of society in the reinforcement and perpetuation
of the status quo, "of those conditions which require
illusions." These charges are hardly new. Indeed,
Kingsley Davis identified The Mental Hygiene Movement,
as the mental health movement was known in 1938, as

> "first ...a social movement a source of advice
> concerning personal conduct, that has inevitably
> taken over the Protestant Ethic inherent in our
> society, also as the unconscious system of
> premises upon which its "scientific" analysis
> and its conception of mental health itself are
> based. Second, that this unconscious incorp-
> oration of the open-class ethic has made mental
> hygiene doubly susceptible to the psychologistic
> approach to human conduct ...third, that the
> unconscious assumption of the dominant ethic,
> together with the psychologistic interpretation,
> has served to obscure the social determinants of
> mental disease, and especially the effects of
> invidious or emulative relationships."[9]

Unlike the physical and organic, when reference is
made to a person's state of mind it is made to those
behaviours and communications which are manifest. This

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communication may be verbal or non-verbal (gesture).
If it is largely by gesture or "body-language" then the
observer must rely heavily upon "intuitive understanding,"
that is, upon the amount and kind of empathy that can
be aroused. In any event, understanding depends upon
interpretation; interpretation, necessarily, invites
evaluation. For example, if a person states that he is
Napoleon, or Jesus Christ, or that he is being constantly
spied upon, watched, or persecuted, these would be
considered symptoms of mental disorder only if the
observer believed that the individual was not Napoleon,
Jesus Christ, or being spied upon, persecuted, etc.
An interesting aspect of this situation is that if the
person states and believes that he is like rather than is,
Napoleon or, Jesus Christ it will probably modify the
diagnosis of the observer without changing the apparent
behaviour of the person in question. That is, we can
either be or be like any figure we may choose and emulate
that behaviour and thought peculiar to that figure just
as effectively by both methods.

In any event, it is apparent that the statement "x"
is a mental symptom," involves rendering a judgment.
This judgment entails, moreover, a covert comparison or
matching of the patient's ideas, concepts, and beliefs

with those of the observer and the society in which

they both live. Any notion of mental symptom is, there-

fore, inextricably tied to the social, including ethical

context.[10] To reiterate a point made earlier, the

interpretation of certain behaviours as bizarre and

inappropriate, or ordinary and appropriate, is governed,

mainly, not by any intrinsic quality of the act, that is

by its substantive nature, but by its relevancy to the

context in which it is perceived and in which it occurs.

If we can come to see that the notion of mental-

illness is used to codify more relatively private socio-

psychological happenings of which the observer (psych-

iatrist or diagnostician) forms a part, and that the

observer as well as the observed person is a participant

in the social process he is studying and, that he is

committed to some picture of what he considers reality

and to what he thinks society considers reality and he

observes and judges behaviour in light of these consid-

erations, then we may accept more readily the fact that

"impartiality" and "objectivity" in the mental health

field is more apparent than real.[11]

Part of the difficulty is caused by the "social

distance" separating observer and observed. That is,

the extent to which the effects of differences in educ-
ation and social experiences necessarily vitiate and
obscure the process and quality of effective communication.
If we choose to extend this view from an intra-cultural
level to that of inter-cultural communication processes,
we may grasp more quickly how the interpretation of
cultural and/or social phenomena necessarily involves the
interpretation of the meaning of various symbols and
signs. Unlike natural phenomena - at least not to the
same extent - the interpretation of cultural signs and
symbols is heavily dependent upon cultural values, that
is, by ethno and ego-centric considerations, the subtle-
ness and extent to which, I believe, we are not fully
aware, much less willing to admit.

Certainly the mental health worker and professional
may criticize particular norms; but he cannot impugn
the basic institutions of his society because it is in
terms of these that conduct is ultimately judged to be
satisfactory or unsatisfactory, his own included. The
particular nature of the social reality which the mental
health professional holds has been formed, in large
measure, by assimilation of the dominant values and ethic
of the society and reinforced through the system of
education and kind of training he has received.

2. Individualism and Psychologism

The emphasis of the training of workers in the mental health field has been highly slanted and favourable to a psychological interpretation of human behaviour, of human thought patterns and processes. In short, the worker is trained to look for bio-genetic rather than social determinants.[12] This is consistant and in keeping with western society's preoccupation with the "psyche" and "introspection", that is, psychological fetishism.

By perpetuating psychologism, that is, the explanation of human behaviour in terms of traits originating within the individual, as opposed to traits originating within society, mental health workers have given Protestant Individualism a "scientific rationalization."[13] as Kingsley Davis puts it,

> "psychologism is a means whereby an unconsciously held ethic may be advantageously propogated under the guise of "science." It protects the (mental health professional) from a disconcerting fact - the relativity of moral judgments".[14]

What the psychologistic interpretation of human behaviour does, Davis argues, is

> "to vitiate the scientific validity of much mental health work by limiting and biasing the study of mental disorder and consequently the working conceptions behind mental health practice. Specifically, the presuppositions lead to neglect

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of the invidious element, in fact social elements
generally, as a determining factor in mental
disorder".[15]

Psychologism then, by emphasizing patterns of
behaviour which are supposedly innate and intrinsic,
extols at the same time individualism, the hallmark and
rhetorical base for the development of western society
morality. And it is with this emphasis on individualism
that the larger social perspective is lost and thus the
opportunity for situational or contextual understanding
as well.

CHAPTER VIII

VALUES AND ASSUMPTIONS, IN THE INTERPRETATION
OF HUMAN BEHAVIOUR

One of the best portrayals, perhaps, of the part
that values play in the motivation, construction, and
application of research directed toward the understanding
of human behaviour, may be seen through the monumental
work on the so-called "authoritarian personality."[1] This
study set out to identify specific traits found within
"authoritaritarian personalities." Its purpose was to under-
stand the causes and thus, possibly make recommendations
for the amelioration, of prejudice. In keeping with the
fact that the study arose during World War II when ethnic
and "racial" prejudice and feelings of nationalsm were
running high, and the fact that a considerable number of
the initial investigators were Jewish, at a time when
Germany was persecuting Jews, it is not difficult to see
and sympathize with the authors intentions. In a word,
the objective of the study was not simply the "... descr-
iption of prejudice but its eradication."[2] It was their
hope that the study "....cannot help but bring (them)
closer to the theoretical, and ultimately to the pract-
ical, solution of the problem of reducing intergroup
prejudice and hatred."[3]

At first glance, this appears to be a worthy goal indeed. Few, I believe, would argue against it. By employing terms such as "authoritarian", "racist", "bigot", "discrimination", "prejudiced", "anti-semetic", we may begin to see that the study was hardly neutral. These are not neutral terms but are laden with pejorative implications and meanings. In this sense, the prepossessions of the investigators are evident and find their way in and are reflected through the nature and framework of the hypothesis they have constructed to test. With this thought in mind we may begin to see more clearly the authors' motivation. It is not guided by considerations of normalcy, that is, by its relevancy to the context in which it occurs but by its value as a social "good" or social "bad", that is, by normative considerations.

Whether or not an act or behaviour is "good" or "bad" does in no way reflect its propriety or inpropriety. Prejudice, to use Adorno's example, is but one of an infinite variety of possible combinations of historical socio-cultural constraints which are manifest through the personality. Some people, but not all and not necessarily and not all of the time, manifest behaviour in words, gestures, and acts which we choose to label as prejudiced. This behaviour so labelled, however, is not,

in any way, reflective of the total personality.[4]

All people are, more or less, not necessarily, and
certainly not all of the time, prejudiced. It seems that
mankind is never without this phenomenon; it may be found
in everyone, to varying degrees, performing various psycho-
social services. It is, then, by this criterion at least,
a universal phenomenon. By the same token we may conclude
that it is a normal (natural) human way of responding,
acting, and thinking in and to various life situations.[5]
While this does not in any way legitimize prejudice as
desirable, it does not, on the other hand, detract from
its credibility, usefullness, or utility, as a psycho-
social mechanism.

Behaviours and attitudes that are labelled as
prejudiced and those that are labelled as schizophrenic
are both viewed as socially unacceptable. The only real
difference between them is that the prejudiced person
is held responsible and accountable for his behaviour
and thoughts whereas the schizophrenic person is not.[6]

If we look more closely at the Adorno study on
authoritarianism, we begin to see that what the investi-
gators meant when they stated that their efforts were
designed to eradicate prejudice was not to eradicate

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prejudice per se, but only particular prejudical acts, behaviours, and attitudes. In fact what they sought to eradicate was the epiphenomena of prejudice i.e., racism, anti-semitism, bigotry, and various forms and expressions of discrimination, but not prejudice itself. The acceptability or unacceptability of these epiphenomena is not predicated upon any considerations of what is normal, we must remember, but on purely normative grounds,[7] upon their subjective evaluation as social goods. This evaluation is more a reflection upon the values and lifestyles of the investigator rather than upon the values and lifestyle of, in this instance, the prejudice of the person.

Most investigators have, as part of their prepossessions, a set of values concerning mankind which they hold and apply as universally valid, if not universally true. These ideals and goals concern the concepts, nebulous as they may be, of human dignity, equality, and freedom. It is also known that these ideals are firmly incorporated and form a basic part of the cultural fabric of western civilization where they represent virtues, that is the ultimate goals to be realized through strife and sacrifice. Thus, when we speak of human dignity and integrity of the individual it is in light of a western predilection, orientation, definition, and criteria. And

if we speak of equality, socially or politically, we mean within a framework of reference familiar to us; as we concieve and experience it. Again, as prejudice is, supposedly, the antithesis of these virtues, and of social "goods" generally, it must be eradicated. Unfortunately, we continually close our eyes and fail to see that equality, in our terms and by our criteria, for some people, between some people, may mean inequality for others; that freedom for some, by our criteria, may mean denial for others; that self-determination may simply be a clever rhetorical rationalization by which people with power and influence may exert their will and privileged position over others. Most important of all, we fail to see that a direct correlation may exist between the attainment and practice of these "virtues" by some and their subsequent denial to others.

The same arguments may be applied to the field of mental health. What the mental health movement seeks to do, like Adorno and the epiphenomena of prejudice, is to eradicate mental illness. It has as its goal a mentally healthy population. Like the investigators of the "authoritarian personality", however, the mental health movement fails to see that what it is directing its attention to is not mental illness per se, but the epiphenomena of mental

illness. That is, to particular behaviours and thoughts. Necessarily, the arbitrary selection of some acts and behaviour as indicative of disordered or disturbed thought, without special reference to the context and dynamic interrelationships and inter-dependency which those selected have with all other acts performed, and without reference to any historical development must, unavoidably, prejudice the interpretation of the phenomena under study. Indeed, the very fact of arbitrary selection, whether done individually or collectively, implies that someone, somewhere, is making a choice. Moreover, that choice involves rendering a value judgment. What is being assessed is the acceptability or impropriety of an act by the investigator's terms of reference. This means that not only is the efficacy of the behaviour in question as a departure from the norm being established but also some assumption as to what the behaviour should be - or should have been. This demands that the investigator possess some understanding not only of the dynamics of the person's life situation and experiences but he must infer from this the dynamics of his thought process as well. The "relative" disorganization of the person's thoughts may be inferred from what he says and from how he acts, and from the observed or inferred discrepancies, real or apparent, which exist between his thoughts and his acts.

The basis upon which the investigator evaluates
the propriety of another person's behaviour is rarely
upon the objective nature and quality of the act. What
almost always occurs is that it is interpreted and evalu-
ated in light of how he, the investigator, would act and
behave in similar circumstances. Thus, it is easy to see
how success in therapy and counselling is usually acknowled-
ged when the therapist's views are successfully integrated
and transposed onto the patient's; the patient's views
and behaviours becoming, then, normal, i.e., socially
acceptable, as accredited by the therapist.

This is hardly a new view. It is one, however,
which continues to be ignored due, in part, to its
challenge to the conventional therapeutic milieu where,
it is assumed, the aims and goals of the treatment agency
are good and correct and those of the patient in need
of correction.

In imposing largely middle-class values and
standards of performance on people without regard to
their relevancey, truthfullness, or credibility, the
mental health movement has ignored and failed to grasp
that what the patient does or does not say and do has
meaning for him at least, within the context of his

own life situation. What he says and does is relevant and expressive of his own particular world view.[8] The onus, it is obvious, is on the therapist or observer to discover and become familiar with the world-view of the patient. He must come to see the world through the patient's eyes. This does not mean or presuppose that the patient's view is truthful and undistorted. Nor does it mean that the therapist's view is the touchstone of reality. It simply means that through establishing a degree of understanding, some sort of effective communication can take place allowing both therapist and patient the opportunity of discovering just how contextually relevant (truthful) or irrelevant their respective views are.

What usually occurs is the opposite. Hospitalization and the psychiatric interview, besides being generally degrading experiences or "ceremonials", have the unique qualification of taking the person out of context, that is, out of the circumstances of his social enviornment. This hampers rather than facilitates understanding because of the intimidation of hospital and psychiatric office. Ideally, hospitalization and the psychiatric interview allow for treatment of the person <u>as he really is</u>, operating within the context and familiarity of his own social milieu.[9] The disparity between peoples behaviour either in or

out of context hardly requires elaboration here. It
goes without saying that few people are in context in
a mental hospital or psychiatrists office; not at first
at least. Few people can act and operate normally or
even effectively in these situations if they are there
because of doubts about their sanity. Like any other
situation, behaviour in a mental hospital or psychia-
trist's office will be constrained in such a way that
it will lend credibility and substance to the question
of abnormal symptoms.[10]

But to treat the person within the framework of his
social environment is not, by itself at least, the
answer. The main reason is that psychiatric and mental
health workers are simply too well taught in the convent-
ional methodologies which, especially today, stress
inculcation and manipulation rather than development,
the end result of which is the making over of the
individual in an approved rather than improved form.[11]

Just how the methods of treatment employed in the
mental health field work in the changing of attitudes and
behaviour has never been accurately determined. What
data exists seems to indicate that it is purely a matter
of chance. But faith in these methods as a means of
social control has never been doubted. Borne along by

treatment methods the significance of which it neither
understands nor can explain, applied to an entity, the
human mind, which it also cannot explain, the mental
health movement, supported by society at large, exorcies,
drugs, and imprisons for indeterminate periods those
who deviate and depart from prescribed paths of conduct
and thought. Simply, no society can tolerate the thought
that those who choose to desert it may be acting in a
rational manner. Society's deviants, like Doctors'
mistakes, must be explained away and the assumption that
the insane are not responsible for their actions provides
the proper and indeed the perfect explanation. Obviously,
only someone who is quite "mad", or not in his "right
mind", "duped", or "misguided", would commit such
treasonable acts.[12] To reiterate the theme of
Halliday's book on The Sick Society,[13] we constantly
fail to distinguish between the sick life and the
sickness; the emphasis is on adjustment to rather than
adjustment of, mans' social environment.

SUMMARY

At the beginning of this paper an overview of
statistical information was given illustrating the
dimensions of the purported mental health problem in
Canada. What was subsequently demonstrated was that
these figures are suspect in light of the general lack
of specificity, precision, and common agreement in
meaning of the term and concept of mental illness.
Indeed, the factor of cultural relativity in itself
and its influence on purported universals in diagnostic
techniques makes the credibility of the mental health
movement suspect. The understanding of human behaviour
is relative and inextricably tied to the social/cultural
context in which it occurs. The systems of identific-
ation do not allow this flexibility. This raises the
suspicion that a person becomes a mental patient more by
chance than by actual design. However that may be,
once he or she does, it is extremely difficult to
escape their new role (that of being mentally-ill).
A psychiatric diagnosis, whether it takes place in a
hospital or psychiatrist's office, has special signifi-
cance and meaning, for both patient and psychiatrist:
it becomes a self-fulfilling prophecy.

Once a person is identified or tagged as being mentally-ill, his behaviour is coloured and constrained by that label. And mental hospitals and psychiatrists' office are "special environments" in which the meanings of behaviour are heavily slanted to be interpreted in certain ways. That is, one's peculiarities, whatever they may be, are reified. It is a small step from reification to pathology.

What has been suggested throughout this paper is that it is more by the norms, values, and myths in existence at any particular time in history that a person comes to be viewed and labelled as mentally-ill, as "mad", as "lunatic", than by any intrinsic nature or quality of the act or behaviour expressed. How we choose to define an act will, to a large extent, determine our relations and reactions to it. In all cases, it is a matter of how we construct our reality (our world) and how we interpret it. Insofar as natural phenomena is concerned, we impose upon it (the objective reality) an order which, to greater or lesser degree, reflects a certain amount and kind (quality) of utility. More important, we constrain our reactions and quality of relationships to that reality by virtue of our particular definition of it. Simply, how we choose to define and

view reality (construct reality) does not in any way affect the reality but will affect our attitude, approach, relationships, and experiences toward and with the reality. "Insofar as thought is directed toward a physical reality", Cassirer tells us,

"... it must endow this reality with determinate characteristics of quantity, shape, and number; it must concieve of it as many, large, or small, endowed with this or that spatial extension and figure. On the other hand, it has no bearing on this reality that it be apprehended as red or white, bitter or sweet, fragrant or maladorious; for all the denominations are merely signs that we use for changing states of being, states that are external and accidental to being itself."[14]

Cassirer' insights, with little modification, are applicable to social and cultural phenomena as well. But unlike natural or physical phenomena, when we define social reality, that is, human behaviour, relationships, and conduct, a certain reciprocity occurs between the observer and observed. The observer does not stand apart and remain unaffected by the social reality he has entered, constructed, and is observing. Nor is the observed unaffected and unresponsive. Both are affected by virtue of their unique histories of development and by the extent and kind of circumstance which has brought them together.

If we relate this knowledge to various epochs we

may see that man constructs and offers rationalizations
for his reality, and for what he does, in various ways.
We may also see that these rationalizations are, more
or less, utilitarian. So are the present-day ration-
alizations covering so-called mental illness. If any
truth is to be found in the mental health field it is
to be found in the fact(s) that today, we are no closer
to understanding the phenomena of so-called mental
disorders than have any of our predecessors. As long
as so-called unsophisticated witch-doctors, medicine-
men and an assortment of faith healers enjoy as much
"success" as do our highly trained, educated profess-
ional mental health workers, we are forced to acknowl-
edge and concede that we know little about human
behaviour and the complexity of thought processes. And,
as long as these unsophisticated people continue to
rely heavily upon the faith and belief which the patient
has in them rather than upon the sophisticated
terminologies and vocabularies of their professional
counterpart, we have to ask questions concerning the
relevancy of much of the present training for mental
health workers. To elaborate on a remark made by
Thomas Scheff, not only have we not begun to ask
ourselves the right kinds of questions, insofar as
the field of mental health is concerned, we have not

begun to question the social reality which inevitably
constrains the kinds of questions we may ask. Until we
can break out of and away from the dominant conceptual
scheme, we shall never begin to look at mental illness,
much less any other kind of deviant behaviour, in new
ways.

CONCLUSION

People may or may not be becoming "madder" than
previous. It is my opinion that they are not; that
there is evidence to show that there is now, as there
always has been, about the same proportion of eccentric
and idiosyncratic behaviours existing with given popula-
tions, at any particular time. Our toleration and
acceptance of any behaviour outside of an ever narrower
norm is, however, becoming less and less - notions and
rhetoric of liberalism and human freedom notwithstanding.
To reiterate a sociological theme, we should not look to
those people whom we choose to label as "mad" for the
answers to their "madness" but, rather, to those systems
of laws, customs, and norms (in short, to the social
reality which obtains) as these are institutionalized and
find expression in and through the dominant socio-economic
institutions of our time. For it is in these systems,
their structure and system of operation and their demands
upon man's emotions, that the real madness lies. Our
fetish with psychological phenomena has only served to
divert man's search and attention away from his social
condition. By so doing, we may begin to see that just
as anthropology is, according to Kathleen Aberle, the
"handmaiden of imperialism", then surely the psycho-

logical disciplines and the mental health movement are
the "handmaidens of madness".

More and more, on an unprecedented scale, industrial
man is having his behaviour constrained and channelled
into specifically defined roles by virtue of the kinds
of specialization which complex industrial society
demands, and by the concomitant legislation and enact-
ment of laws which effectively define the extent and
kinds of ways in which people are obligated one to
another. These laws and statutes unavoidably constrain
behaviour. Insofar as laws define and allow the number,
structure, and kind of social institutions, whether
these be economic and/or political, so too will they
define and determine the kind of relationships between
institutions; so too will they define and determine
human behaviour and mans' consciousness as it is
allowed to develop and operate within the context and
constraints of those institutions.

What is being suggested here is that there may or
may not be any increase in incidence and prevalence
of so-called mental disorders within the Canadian
population - even allowing for the increase in personnel
and sophistication of present-day diagnostic techniques

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and epidemiological surveys. Any suggestion of increase
may simply reflect nothing more than a growing intol-
erance throughout society as a whole, finding expression
in and through the elaboration and expansion of resources
in the mental health field. In a word, as the complexity
of our respective roles grow and increase in number we
are, at the same time, constrained to ever narrower
ranges of behaviour within those roles. The demands of
sophisticated, complex technological arrangements and
supporting specialization, demands an accompanying
social specialization as well; the discipline of science
and technology demand discipline in the social sphere
as well. A direct inter-dependency exists between the
two; one is not capable of coming into existence without
the other.

The values and norms reinforcing, perpetuating,
molding and modifying roles and behaviour are of interest
here, as are thier history and development. Until the
independence of value judgments from diagnostic and
evaluative techniques and procedures can be demonstrated,
the entire argument of rising prevalence and incidence
of mental disorder in the Canadian population remains
questionable and suspect. Thus far, the mental health
movement has failed to address itself to this question.
By so doing it can only cast doubts on its own credibility.

CHAPTER I

1 This is not to argue the lack of real precision and ambiguity present in those systems in their everyday application.

2 This is a gross simplification. It does not take into consideration the constitutional allocation of powers and responsibilities as set out in the British North America Act regarding federal, provincial, and muncipal governments. In this respect, the criminal code remains as the most uniformly applied legislation governing human conduct across Canada. This simplification is, however, suited to the purpose here.

CHAPTER II

1 It has been only in the past seven or eight years that the methods and practices of data gathering by the Statistics Canada (formerly The Dominion Bureau of Statistics) have been sufficiently upgraded and refined to allow other than the most superficial of impressions and conclusions to be drawn from their figures. The same situation may be found to exist in the field of corrections.

2 "Psychiatric institution" is used generally and includes designated public mental hospitals, psychiatric hospitals, and public psychiatric units of general hospitals.

3 Mental Health Statistics, occasional catalogue number 83-506, October, 1968, pp.8, Dominion Bureau of Statistics (Statistics Canada), Ottawa, Canada.

4 Assuming that diagnostic techniques have some credibility studies such as Robert and Helen M. Lynds Middletown (Harcourt, Brace & Co., New York, U.S.A.,1929), and August Hollingshead & Frederick Pedlichs, Social Class and Mental Illness (John Wiley & Sons Inc., New York, U.S.A., 1967) seem to offer support to the notion that by far the majority of people deemed to have mental disorders escape detection - at least "official" recognition.

5 _Mental Health Statistics_, op. cit., 1968, p.8.

6 _Ibid._, "Patient Movement", 1969.

7 More important, perhaps, is the suggestion that study of this phenomena would provide some clarification of the data Hollingshead and Redlich provided in their study of _Social Class and Mental Illness_; that is, that specific age groups vary in their susceptability to emotional disorders as they do - or are reported to do - with the socio-economic group to which they belong.

8 _Mental Health Statistics_, op. cit., Preliminary 1969. "Admissions" include: first admissions (those without a record of previous care in a psychiatric in-patient facility), readmissions (those admitted who have a record of previous care in a psychiatric in-patient facility), and, transfer-in (those admitted directly from another psychiatric in-patient facility).

9 _Ibid._, "Patients on Books" include: in addition to patients actually in residence, those absent on probationary leave, boarding in approved homes, or otherwise absent from the institution but not officially separated.

10 _Ibid._, "Patient Movement", 1969.

11 _Ibid._, "Patient Movement", Preliminary, 1970.

12 _Ibid._, "Patient Movement", Preliminary, 1971.

13 _Ibid._, Vol.I, "Institutional Admissions and Separations", 1961-65, 83-204, p.20, 1961.

14 _Ibid._, 1964, p.30.

15 _Ibid._

16 _Ibid._, Supplement: "Patients In Institutions",1961, 83-208, p.7.

17 _Ibid._, "Institutional Admissions and Separations".

18 _Ibid._

19 _Ibid._

20 cf. Mental Health Statistics, op.cit., 1955, where
in 1955 eight per cent of patients in institutions had been
under care for less than 4 months, rising to 11 per cent in
1961.

21 Canada's Mental Health, hereinafter cited as C.M.H.)
Vol.18, No.12, March-April 1970, p.25; published by the
Department of National Health and Welfare, Ottawa. Figures
previous to this period are incomplete, lack precision, and
are therefore suspect.

22 Mental Health Statistics, op.cit., Preliminary,1969.

23 Ibid., 1970.

24 Ibid., Catalogue 83-208, Vol. 2, 1962, p.9.

25 Ibid.

26 Ibid.

27 Ibid., Catalogue 83-208, Vol. 2, 1965.

28 Ibid., p.16.

29 cf. Homemaker's Digest, Nov/Dec. 1970, Issue 6,
Vol.5, p.9.

30 Ibid. Compare also an article titled: "Speed Used
On Unruly Students" (The Sun, a Vancouver newspaper,
March 29, 1971, p.33) in which the use of methylophenidate
and dextroamphetamine (dexedrine) on hyperactive children
is discussed. "Hyperactivity", refers to those children
who are "...noisy, aggressive...(and who) can't concentrate
for more than a few minutes at a time, and (who) have to
keep moving". See also "Retreats Favoured For Harrassed
Mothers" (The Sun, Wednesday, March 1, 1972, p.22) where it
states, in part, "one million Canadian youngsters, ranging
in age from one to 19 years are suffering from some form of
emotional and/or learning disorders".

31 Special Report on Schizophrenia, U.S. Department of
Health, Education, and Welfare, Washington, D.C., 1970;
cited in full in This Month, a monthly publication of
The Psychiatric Nurses Association of British Columbia,
Vol.2, No.10, October, 1970, pp.32-47 inclusive.

32 <u>Mental Health Statistics</u>, op.cit., Catalogue 83-208, Supplement, "Patients in Institutions", 1961, p.9, where it is stated "Schizophrenia...was the most prevalent of the mental disorders constituting...35 per cent".

33 <u>Ibid</u>.

34 <u>Ibid</u>., Catalogue 83-205, Annual, vol.3, "Institutional Facilities, Services, and Finances", 1970, p.23.

35 <u>Ibid</u>. 1962, p.24.

36 <u>Ibid</u>. 1966, p.19.

37 "Therapy Programs Need Funds", <u>The Sun</u>, Wednesday, March 1, 1972, p.22.

38 <u>Mental Health Statistics</u>, op. cit., Catalogue 83-205, 1962, p.27.

39 <u>Ibid</u>., 1966, p.22.

40 <u>Ibid</u>., p.16.

41 <u>Ibid</u>., 1970, pp.20-21.

42 Myron Wilson, "Mental Illness: Its Our Greatest Public Health Problem", <u>Weekend Magazine</u>, May 8, 1971, p.9.

CHAPTER III

1 <u>C.M.H.</u>, op. cit., Supplement No. 56, "Unsolved Problems of Prevention", (quotation on cover).

2 <u>Ibid</u>.

3 "Is The Couch on the Way Out"?, contained in Hobart O. Mowrer's (ed.) <u>Morality and Mental Health</u>, Rand & McNally and Co.,Chicago, U.S.A., 1967, pp.15-23.

4 For an historical view I direct the reader to three excellent documentations: Michel Foucault's <u>Madness and Civilization</u> (Mentor Books, Random House Inc., Ontario, Canada, 1967); George Posen's <u>Madness In Society: Chapters in the Historical Sociology of Mental Illness</u> (Harper & Row New York, U.S.A., 1969); and Thomas Szesz's <u>The Manufacture of Madness</u> (Harper & Row, New York, U.S.A., 1970).

5 C.M.H., op. cit., Supplement No. 56, p.3 .

6 Thomas Scheff, Being Mentally Ill, Aldine Publishing Co., Chicago, U.S.A., 1966, p.7.

7 Ibid.

8 Ibid. cf. also an article titled: "Riverview Adopts New-Type Therapy" (The Columbian newspaper, New Westminster, B.C., Wednesday, July 22, 1970, p.3) where behaviour modification, using a reward system of tokens, is heralded as a "new behavioural therapy".

9 Throughout this paper the terms mental disorder and mental-illness are used interchangeably. This does not mean or imply agreement with the terms or attribute credibility to them. All it indicates, at this time, is the lack of alternate concepts which would convey the same general meaning and elicit the same general response in the reader.

10 See especially The Special Report on Schizophrenia, op. cit., p.46, where it is stated: "despite the recent proliferation of studies ...in the development of schizophrenia, whether the phenomena described (i.e., metabolic and endocrinic imbalances, abnormal E.E.G.'s genetic and organic abnormalities, social and environmental deprivations) are products or causes of the illness is unknown; nor is it clear that these factors are specific to schizophrenia, rather than more general phenomena associated with any number of psychopathologic conditions" (emphasis added).

11 Althought Dr. Pauling's field is not, properly speaking, the field of mental health but chemistry, it is related to man's physical well-being and mental health generally. His comments and insights, therefore, are of interest and certainly to be considered expert opinion insofar as certain body chemical imbalances suggest a correlation with mental disorders.

12 C.M.H., op. cit., Vol.16, No.5, Sept.-Oct. 1969, p.41.

13 Ibid.

14 "Vitamins Give Hope For Mental Illness" (The Sun, Wednesday, November 29, 1972, p.36).

15 Ibid. We might add that the idea of corporeal physiological origins of human behaviour extends back more than a mere ninety years. Certainly the Greeks and their ideas of the humours, of bile or bilious behaviour, sanguine, and phlegmatic conditions are quite in keeping with our current notions about metabolic and endocrinic imbalances.

16 "Findings Made In Schizophrenia" (The Sun, Tuesday, May 9, 1972, p.40).

17 Ibid.

18 "Discovery Linked To Mental Disorders" (The Sun, Friday, July 9, p.9).

19 Ibid.

20 The Sun, Thursday February 11, 1971, p.67.

21 C.M.H., op. cit., Vol.17, No.5, Sept.-Oct. 1969.

22 Ibid.,p.39.

23 Ibid.,p.40.

24 Ibid.

25 The standard rationalization employed by experts, whether these be therapists, administrators, or bureaucrats, to avoid other than superficial involvement, is that those kinds of decisions and involvements have political overtones in the sense that they reflect upon the values and goals of the administrative arm and the order of priorities of the sponsoring agency, which is usually the government. Decision making with political overtones is to be avoided at all costs. What these people fail to see, much less are willing to acknowledge, is that irrespective of whether or not they choose to become involved, they are unavoidably involved already. All that remains to be decided is the kind of political direction they will take, i.e., support for existing policies or trying to change them.

26 cf. The History of Psychiatry,(Franz G. Alexander and Sheldon T. Selesnick, Mentor Books, New York, U.S.A., 1968). These two supporters of current psychiatric practice offer legitimacy by way of demonstrating a historical, developmental view, in which psychiatry comes of age and matures, by becoming a "science" of human behaviour and understanding .

CHAPTER IV

1 Culture and Social Psychiatry, Atherton Press, New York, 1967.

2 Culture and Personality, Random House, New York, 1970.

3 Culture, Language and Personality, edited by David G. Mandelbaum, University of California Press, 1966.

4 Historism, or Historismus, as it is in German, means the treatment of all statements, pronouncements, and value judgments historically; as parts of an ever changing development. In this view nothing appears fixed, immutable and permanent; everything flows. In this way contemporary truths may be seen as a conditional part of our epoch as the Spanish Inquisitor's were of his.

5 "A Critique of Culture-Personality Writings", by Alfred Lindesmith and Anselm Strauss (American Sociological Review, 1950, Vol.15, No.5, pp.587-600).

6 Ibid., p.591.

7 We must not ignore the more obvious bias which is built in to the kinds of tests we choose to construct to extract various kinds of information, that is, psycho-social tests. For a penetrating analysis and criticism of these tests and one which allows some sense of perspective by demonstrating weaknesses and strengths, I direct the reader to Pitirim Sorokin's classic work titled Fads and Foibles In Modern Sociology and Related Sciences (Henry Regnery Co., U.S.A., 1956); see also "The Problem of Quantification in Psychological Science" (Daniel Brower, Psychological Review, Vol.56, 1949, pp.325-333).

CHAPTER V

1 See especially the article "Interdisciplinary Collaboration in Mental Illness Research" (Ozzie G. Simmons and James A. Davis, American Journal of Sociology, Vol.63, 1957/58, pp.297-303) where conceptual differences between disciplines are discussed.

2 Special Report of Schizophrenia, op. cit., p.33.

3 Ibid.

4   Ibid.

5   Ibid., p.3.

6   Thomas Scheff, Being Mentally Ill, Aldine Publishing Co., Chicago, U.S.A., 1966, p.7.

7   Ibid., p.9.

8   Benjamin Braginsky et al, Methods of Madness: The Mental Hospital As A Last Resort, Holt, Rinehart & Winston Inc., U.S.A., 1969, p.179.

9   Ibid.

10 Ibid., p.180.

11 The Revolution In Psychiatry, Free Press, New York, U.S.A., 1964.

12 Ibid., p.207.

13 A.B. Hollingshead & F.C. Redlich, op. cit., pp.372-73.

14 Thomas Szasz, The Myth of Mental Illness, Dell Publishing Co., Inc., New York, U.S.A., 1961.

15 The Manufacture of Madness, Harper & Row, New York, U.S.A., 1970.

16 Ibid., p.XV.

17 Michel Foucault, op. cit.

18 George Rosen, op. cit.

19 Karl Menninger, The Vital Balance (MacMillan Co. of Canada Ltd., 1964). For the pejorative implications of labelling people mentally-ill, compare the argument of Albert Ellis ("Should Some People Be Labelled As Mentally-Ill") and a rebuttal of that argument by T.R. Sabin ("On The Futility Of The Proposition That Some People Be Labelled Mentally-Ill"); both articles contained in the Journal of Consulting Psychology, 1967, Vol.31, No.5, pp.435 ff.
        See also Harold Garfinkel, "Conditions of Successful Degradation Ceremonies" (American Journal of Sociology, Vol.61, pp.420-424) where the "psychiatric ceremonial", in which the individual is diagnosed and labelled, is the first step in an otherwise degrading, humiliating experience.

20 Karl Menninger, op. cit., p.5.

21 Ibid.

22 Conservatism here, is used and meant in the Mannheim sense of the influence of the past being a predominant influence on the present and future.

23 R.D. Laing, The Politics of Experience, Random House, New York, U.S.A., 1967, pp.78-79.

24 Ibid., p.79.

25 Whether or not it is "natural" does in no way suggest its value, i.e., whether it is "good" or "bad", appropriate or inappropriate, reconstitutive or disintegrative.

26 Ibid., p.70.

27 Ibid.

28 Ibid., p.74.

29 Ibid.

30 Ibid., p.76 (Laing citing from Erving Goffman's Asylums, Anchor Books, Doubleday & Co. Inc., New York, U.S.A., 1961).

31 cf. Erving Goffman and his many excellent books and essays in which he describes and vividly portrays the subtleties and nuances involved in face-to-face relations, in which various social constraints and predispositions are at work. See especially: The Presentation Of Self In Everyday Life (Anchor Books, Doubleday & Co. Inc., New York, U.S.A., 1959); Asylums (cited above); and Interaction Ritual: Essays On Face-To-Face Behaviour (Aldine Publishing Co., U.S.A., 1967).

32 On one occasion when I mentioned to the head of a psychiatric out-patients clinic (in Vancouver) that I thought that in this particular instance - referring to a Chinese/Canadian family, a son of whom was my client - the psychiatrist should conduct the interview and counselling session in the family home, my suggestion was ignored. Perhaps the suggestion was ignored because it was made in front of the boy. I can, however, offer no real reason why the suggestion was not pursued other than the psychiatrist would not feel as comfortable and as at ease and thus as "professionally assuring" and "comptetent", as he would if he were to remain in his office;

especially so if he were to be seriously challenged and if the interview situation became difficult.

In this particular instance the boy was confronted, within the confines of a room no bigger than 8 x 10 feet, by two psychiatrists, one psychiatric social worker and his probation officer. The boy was intimidated and scared. The opening question by one psychiatrist was a classic: "when did all your problems begin"? It was enough. The boy broke down and wept profusely. More interestingly was the solemnity with which the psychiatrists and social worker approached the interview, indeed, in which they staged the whole "ceremonial". (And we shall comment on this later).

33 Asylums, op. cit.

34 By referring to practice as therapeutic I do not intend to lend credibility to where it is not deserved. I am simply re-stating a correlation that is usually made, held, and applied.

35 Simply put, it is a case of "humanism" versus "rationalism". cf. Max Weber's Literature On The Nature and Goals of Bureaucracies. See also Robert Merton et al, Reader In Bureaucracy, Free Press, New York, U.S.A., 1952. Of additional interest, but not central to the argument at hand, are the kinds of treatment offered within the framework of mental hospitals. That is, the kind and extent of innovation and flexibility which the facts of physical plant and administrative structure will or can allow and accomodate with some measure of success.

36 Braginsky et al, op. cit.

37 Ibid., p.179.

38 cf. Percival Bailey, "The Great Psychiatric Revolution", originally published in the American Journal of Psychiatry (113, 1956, pp.387-406) and more recently in Hobart O. Mowrer, op. cit. (chap. 9, pp.47-65).

39 And, we are not assuming any meaningful correlation here between specific thoughts or thought patterns and behaviour.

40 Frank G. Alexander & Sheldon T. Selesnick, op. cit., pp. 24-25.

41 Ibid., p.25.

42 "Sophistication", is usually measured by way of
the number and quality of degrees and diplomas held,
that is, by educational qualifications. That education,
by way of the content it offers, may simply perpetuate
the same old concepts and "tired" models of human
behaviour and thus effectively circumscribe its own
potential is, I think, of importance but not central to
the argument here.

43 Braginsky et al, op.cit., pp. 1-2.

44 C.M.H., op.cit., Vol. XVII, No.5, Sept.-Oct. 1969,
pp.39-40.

45 Ibid., p.40.

46 Ibid.

CHAPTER VI

1 cf. Braginsky et al, op. cit., pp.4-5; also Erving
Goffman's Asylums (op. cit.), especially the chapter titled:
"The Underlife of a Public Institution: A Study of Ways of
Making Out in a Mental Hospital" (pp.207-302).   The
suggestion of "Patient Rationality" is also emphasized heavily
in the writing of Thomas Scheff (op. cit.) and R.D. Laing
(op. cit.).   It may also be found scattered throughout many
other sources such as George Ichheiser's "Misunderstanding
In Human Relations" (American Journal of Sociology, part 2,
monographic supplement, Vol.55, 1949), Robert Macleod's
"The Phenomenological Approach to Social Psychology"
(Psychological Review, Vol.54, 1947, pp.193-210), and Alfred
Schuetz's "Common-Sense and Scientific Interpretation of
Human Action" (Philosophy and Phenomenological Research,
a quarterly Journal, Vol.14, No. 1, September, 1953).

2 Braginsky et al, op. cit., p.73; see also p.5;
cf. chapter 2: "Experimental Studies of Manipulative
Tactics of Mental Patients"(p.49 ff.). Assuming that these
studies have credibility - and we must make this
assumption or question the credibility of all psycho-social
tests - the suggestion that patients in mental institut-
ions have goals and are capable of achieving them seems
to offer insights into the phenomena of "spontaneous
remissions." That is, when a person "decides" to get
well he may in fact do so. It may also offer insights
into why patients who hide their drugs get better at
about the same rate as those who take them.

3 Ibid., p.7; Braginsky et al, citing data from
I. Helfand, "Role-Taking in Schizophrenia" (Journal
of Consulting Psychology, 20:37, 1956).

4 Braginsky et al, op. cit., citing data from H.M.
Grayson and L.B. Olinger, "Simulation of Normalcy by Psych-
iatric Patients on the M.M.P.I." (Journal of Consulting
Psychology, 21:73-77, 1957).

5 Braginsky et al, op. cit.

6 Ibid., p. 180.

7 Anthony F.C. Wallace, Culture and Personality, Random
House, U.S.A., 1970, p.3.

CHAPTER VII

1 cf. Goffman's Asylums, op. cit., pp. 350-52.

2 Henry B. Adams, "Mental Illness or Interpersonal
Behaviour?" A revised version of a paper presented at the
70th Annual Convention of the American Psychological
Association on a symposium entitled: "Mental Illness: Is
There Such A Thing?" (St. Louis, Missouri, U.S.A., August
30, 1962).

3 Ibid., p.193

4 Ibid., p.194

5 Ibid.

6 Gordon W. Allport, "Scientific Models and Human
Morals", Psychological Review, Vol.54, 1947, pp.182-191;
p.183.

7 cf. Kingsley Davis' celebrated essay on "Mental Hygiene
and Class Structure", contained in Arnold Rose (ed.),
Mental Health and Mental Disorder, W.W. Norton Inc., U.S.A.,
1953, pp.578-598.

8 C.M.H., op. cit.,Vol.17, No.2, March-April 1970,p.44.

9 Kingsley Davis, op. cit., p.581.

10 Kirson S. Weinberg (ed.), The Sociology of Mental
Disorders, Aldine Publishing Co., Chicago, U.S.A., 1967,
p.173.

11 Ibid., p.175.

12 Kingsley Davis, op. cit., p.587.

13 Ibid.

14 Ibid.

15 Ibid., p.589.

CHAPTER VIII

1 T.W. Adorno et al, The Authoritarian Personality, Harper & Row, New York, U.S.A. 1950.

2   Ibid., p.VII, (part one).

3   Ibid., p.VIII.

4   This has, in my opinion, constituted one of the principal reasons substantiating the incongruities and inconsistancies in subsecuent research into and explanations of, The Authoritarian Personality. For an elaborate articulation of some of the major problems research into this area has encountered see John P. Kirscht and Ronald C. Dillehay's Dimensions of Authoritarianism: A Review of Research and Theory, University of Kentucky Press, U.S.A. 1967.

5   An interesting extension of this argument demonstrates that the value of any act is in the eyes of the "beholder", not the beholden. Rarely does a person view himself as prejudiced, as a bigot, racist, or as authoritarian. By the same token, a person other than a "believer" (one who is caught up in the introspective game of self-analysis) rarely sees himself as mentally-ill.

6   This is not to ignore some of the implications that Adorno's study drew: that some prejudiced people may be mentally-ill as well.

7   It shall not be argued here such notions as defining the "abnormal" as that which departs or deviates from the "mean" or "norm"; that is, the credibility of statistical criteria for determining pathology; or by looking to man's "positive strivings" as the basis for guaging normal behaviour. These arguments have already been well documented. See especially Leslie Rabkin and

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L. Carr (eds.), Source Book in Abnormal Psychology
(Houghton & Mifflin Co., Boston, U.S.A., 1967); Arnold M.
Rose (ed.), op. cit.; and Henry Wegrocki, "A Critique of
Cultural and Statistical Concepts of Abnormality"
(Journal of Abnormal and Social Psychology, 1939, 34,
pp.166-178).

The weakness inherent in most arguments of this nature
is that some notion of normal behaviour is implicitly
held and employed by the investigator. This preconception,
in the instance of cross-cultural studies, smacks of
ethno-centrism and, in sub-cultural studies, smacks of
ego-centricity. See also the paper by A.R. Lindesmith
and A.L. Straus, op. cit.

8 It goes without argument that while in fact the
statement by Cassirer is not entirely accurate it remains
suited for the purposes here. Man, as he interacts with
his environments, cultural or physical, is affected and
influenced as he affects and influences those environments.
Differences in effect, in any qualitative sense, between
the cultural and physical environs are, at first glance
apparent, if not self-evident. Whether those differences
have in fact any substantive basis and are, therefore
more real than apparent remains to be argued elswhere.

Also of interest and relevant to certain aspects
of the thesis being presented, a statement by Ernst
Cassirer: "even the world of lunatics reveals to an attentive
analysis some definite regularities which find their
expression in queer but still understandable symbolic
forms". (Cited in Paul Schilpp (ed.), The Philosophy of
Ernst Cassirer, Harcourt & Brace, U.S.A., 1967, p.26).

See also Karl Menninger (op. cit.) where he
states that the world and expressions of the so-called
mentally-ill people can be understood if the therapist can
escape, so to speak, the constraints of his own perspective
and become contextually sympathetic with the world-view
of the patient.

9 C.M.H.,op.cit.,Vol.15,No.5&6,Dec. 1967, p.10-11.

10 cf. Scheff (op.cit.) especially Chap. 4, "Decisions
in Medicine", p.105ff; see also p.130, "Legal and Psychiatric
Screening of Incoming Patients", and p.132, 133, 134.

11 Braginsky et al, op. cit., p.182.

12 Ibid., p.173; also "rational", used here, is
employed in the Weberian sense of being goal-directed and
oriented rather than necessarily logical.

13 James S. Halliday, Psychosocial Medicine: A Study of The Sick Society, W.W. Norton and Co., Inc., U.S.A. 1948.

14 Ernst Cassirer, The Philosophy of Symbolic Forms, Vol.3: The Phenomenology of Knowledge, Yale University Press, U.S.A., 1965, p.19.

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